REPORT 4

ATASCADERO STATE HOSPITAL

April 21-25, 2008

THE HUMAN POTENTIAL CONSULTING GROUP
ALEXANDRIA, VIRGINIA

NOTE

The Court Monitor is responsible only for monitoring and providing an independent evaluation of Atascadero State Hospital's compliance with the Enhancement Plan.

The Court Monitor is not in any way responsible for the services provided at Atascadero State Hospital or for outcomes of these services for any individual resident at the facility during or following the tenure of the Enhancement Plan. Neither the Court Monitor nor his experts are in any way responsible for the administration of the facility, the day-to-day clinical management of the individuals served, clinical outcomes for any individual, staffing, outcomes for staff providing services at the facility or any other aspect of the operations of Atascadero State Hospital. All decisions regarding the facility, its clinical and administrative operations and the individuals it serves are made independently from the Court Monitor.

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Introduction

A. Background Information

The evaluation team, consisting of the Court Monitor (Mohamed El-Sabaawi, MD) and four expert consultants (Vicki Lund, PhD, MSN, ARNP; Ramasamy Manikam, PhD; Elizabeth Chura, MSRN; and Monica Jackman, OTR/L) visited Atascadero State Hospital (ASH) from April 21 to 25, 2008 to evaluate the facility's progress regarding compliance with the Enhancement Plan (EP). The evaluators' objective was to develop a detailed assessment of the status of compliance with all action steps of the EP.

The progress assessment is outlined in this compliance report, which follows the exact sequence of steps as written in the EP. The report covers Sections C through J (Sections A and B contain definitions and principles that do not entail action steps requiring assessment). For each section, a brief narrative summarizes the findings of the entire section in terms of accomplishments and deficiencies. This is followed by details of compliance assessment. The assessment is presented in terms of:

1. The methodology of evaluation, summarized in one cell at the beginning of each section or major subsection (C1, C2, D1 through D.7, E, F1 through F 10, G, H., I and J);
2. Current findings focused on the requirements in each action step of the EP; this includes, as appropriate, the facility's internal monitoring data and the evaluators' monitoring data;
3. Compliance status in terms of the EP; and
4. Recommendations.

To reiterate, the Court Monitor's task is to assess and report on State facilities' progress to date regarding compliance with provisions of the Enhancement Plan (EP) that was negotiated between the State and the United States Department of Justice. In fulfilling that responsibility, the Court Monitor makes recommendations for changes and enhancements to current practices that he and his team believe can help the facilities achieve compliance in the future. The evaluators' recommendations are suggestions, not stipulations for future findings of compliance. The facility is free to respond in any way it chooses to the recommendations as long as it meets the requirements in every action step in the EP.

The Court Monitor's recommendations are guided by current generally accepted professional standards of care, current literature and relevant clinical experience. These recommendations are linked to the current stage of the facilities' implementation of the EP. At early stages, many of the recommendations are more focused on process deficiencies. As the facilities make progress in their areas, the recommendations will be directed to clinical outcomes to individuals as required by specific provisions of the EP.

The EP mandates the findings of compliance, but it does not mandate the means by which the facilities' caregivers and administrators execute their responsibilities to individuals or the processes and tactics by which the facilities achieve compliance with the terms of the EP. As noted earlier in this report and in every previous report, a facility is in fact free to use any mechanisms it wishes to implement and achieve compliance with the terms of the EP. The California DMH, however, may impose certain statewide policies, practices and procedures to effect improvements in its hospitals.

B. Methodology

The Court Monitor's evaluation team reviewed a variety of documents prior to, during and after the on-site evaluation. The documents included, but were not limited to, charts of individuals, facility administrative directives, policies and procedures, the State's special orders, and facility's internal monitoring and key indicator data. The charts of individuals were selected both randomly and on the basis of adverse outcomes in specific areas. While on site, the evaluators also interviewed administrative, clinical staff and some individuals and observed a variety of therapeutic, rehabilitative and other service delivery processes. The data provided by the facility were verified on a random basis to assess accuracy and reliability.

The evaluation team's compliance findings are a function of independent review and judgment, taking into consideration both quantitative and qualitative factors related to the requirements of the particular EP cell.

The evaluation team's quantitative data is typically collected through chart reviews while on site. Sources of qualitative information include: a) chart reviews; b) staff interviews; c) observations of teams, programs and the environment of care; d) assessment of the stability of the facility's current structure and functions in terms of potential for self-sustenance and e) assessment of trends and patterns of change rather than single and/or temporary occurrences that are inconsistent with these patterns and trends.

The qualitative assessment may result in compliance findings that vary from a finding that might be expected if based on quantitative data alone.

The evaluation team may also evaluate its findings relative to data presented by the facility that results from its internal performance process audits. Such audits serve as quantifiable mechanisms for facility self-assessment of progress on EP requirements. The facility's data is often referenced or included in the body of the report, particularly when it illustrates concordance with the monitor's findings, variance from the monitor's findings, or a pattern over time.

In the ratings of compliance, the evaluation team uses a scale of noncompliance, partial compliance and substantial compliance. A rating of noncompliance indicates lack of efforts and progress towards compliance. A rating of partial compliance falls short of the

Court Monitor's threshold of compliance, but indicates progress and efforts towards achieving compliance. A rating of substantial compliance indicates that the facility has met the Monitor's threshold of acceptable progress in implementing specific requirements of the EP.

C. Statistical Reporting

The following statistical abbreviations used in the report are defined as follows:

Abbreviation	Definition
N	Total target population
n	Sample of target population reviewed/monitored
%S	Sample size; sample of target population reviewed/monitored (n) divided by total target population (N) and multiplied by 100
%C	Compliance rate (unless otherwise noted)

D. Findings

This section addresses the following specific areas and processes, some of which are not covered in the body of the compliance report.

1. Key Indicator Data

The key indicator data provided by the facility are graphed and presented in the Appendix. The following observations are made:

a. The key indicator data are an essential ingredient of a culture of performance improvement. While they are provided to the Court Monitor as required by the EP, the primary users of the data should be the clinical and administrative leadership and management of the facility.
b. ASH now reports data on all key indicators. Additionally, the facility has returned to facility-wide reporting for all series with the exception of medication variances (all subcategories).
c. The most significant, and alarming, trend illustrated by the key indicator data is the increase in aggressive acts. Section I.2 of this report contains findings related to this trend.
d. The number of individuals alleging abuse, neglect or exploitation has also risen steadily since the last tour. The provision of a safe environment is a foundational obligation and these trends demand immediate corrective action.

e. It is the monitor's recommendation that the DMH undertake an analysis of each facility's key indicator data on a quarterly basis. The resulting analysis should be reviewed by the State with their Chief CRIPA Consultant. The outcome of this review should be that the hospitals: (a) use the same statewide definitions for all key indicators; (b) standardize their data collection and data analysis methodologies, (b) improve their services, and (c) use the data for future policy decisions. The DMH Chief CRIPA Consultant should update the monitor on these efforts following each review. It is critical that the key indicator data are valid and reliable, and used to enhance the mental health services provided throughout the DMH system.

2. Monitoring, mentoring and self-evaluation

Overall, ASH has made progress in self-monitoring, data gathering, aggregation and analysis and mentoring since the previous assessment. The following observations are relevant to this area:

a. ASH has strengthened its WRP training, including the appointment of a Master Trainer, the assignment of WRPT mentors and initiation of training based on the MSH Modules.
b. ASH has recently initiated a process of review and analysis of the internal monitoring data by the facility's Quality Council.
c. ASH has recently established Medication Management and Medical Services EP Performance Improvement Teams.
d. ASH has implemented the DMH standardized tools in all applicable sections in C.1 and C.2.
e. ASH has strengthened the criteria for self-monitoring of nutritional assessments.
f. ASH has implemented the new DMH standardized tools to monitor its use of benzodiazepines, anticholinergics and polypharmacy.
g. ASH has provided adequate analysis of its self-evaluation data regarding care of specific medical conditions.
h. The facility's self-monitoring data generally had integrity, were reasonably well organized and the data presented were relevant to requirements of the EP.
i. ASH has improved the sampling methodology during this review period. However, further work is needed to ensure acceptable samples of appropriately defined target populations across the board.
j. ASH has improved its analysis of self-assessment data. However, further work is needed to ensure that the analysis adequately delineates areas of low compliance and relative improvement during the current reporting period and compared to the previous period, and is accompanied by plans to improve compliance.
k. All facilities must ensure that discipline chiefs and senior executives review the monitoring data on a monthly basis at the facility level and that results of these reviews are used to enhance service delivery within each facility. As mentioned in earlier reports by this monitor, the monitoring data across hospitals should be reviewed quarterly by the State with its Chief

CRIPA Consultant so that the aggregate data can be used to enhance the mental health services provided throughout the DMH system.

l. The DMH has yet to ensure that the tools and data collection are automated.

3. Implementation of the EP

a. Overall, ASH has developed most of the structures and processes that are required for implementation of the EP. At this juncture, the facility needs to focus its efforts on using the EP processes and monitoring data to refine the quality of clinical services to the individuals.
b. ASH has achieved substantial compliance with the EP requirement regarding the case loads of WRPT members on the admission units.
c. ASH has achieved substantial compliance with the requirement regarding physicians' consideration of pharmacists' recommendations that address new orders.
d. ASH has achieved substantial compliance with EP requirements in section D.7 (Court Assessments); however, continued compliance will require ongoing vigilance in satisfying all the requirements of Section D.7, including D.7.a.i and D.7.c.i.
e. Since the last review period, ASH has made progress in the following areas:
    i. The process of the WRPC;
    ii. The staffing ratios in all admission units (except for RTs);
    iii. The content of case formulations in many WRP;
    iv. The number of active treatment hours for its individuals;
    v. Mall Group offerings and lesson plans.
    vi. The formats for Admission and Integrated Nursing Assessments;
    vii. Time limit regarding the ordering of PRN medications;
    viii. Data collection mechanisms for reporting of adverse drug reactions and medication variances;
    ix. The process of Intensive Case Analysis of Adverse Drug Reactions;
    x. Timeliness of Integrated Psychology Assessments;
    xi. Dental care services and staffing;
    xii. Steps to revise Medical Care Policies and Procedures to address the deficiencies identified by the Court Monitor;
    xiii. Quality (not timeliness) of investigations of abuse/neglect; and
    xiv. The process of review of individuals who have reached behavioral triggers.

f. ASH has maintained compliance with the requirement regarding after-hours coverage by Psychiatric and Medical Officers-of-the-Day.

d) ASH has maintained quality improvements in nutritional assessments and services.
e) ASH has yet to make progress in achieving appropriate linkage between interventions provided at the PSR Mall and objectives outlined in the WRP.
f) ASH has to ensure that the Psychiatric Reassessments provide a more concise, individualized and meaningful review of clinical data.
g) ASH needs to finalize and implement the draft revisions of its medical policies, procedures and standardized monitoring instruments to ensure correction of process deficiencies in the delivery of medical services.
h) ASH has to develop and implement mechanisms to improve nursing attention to changes in the physical status of individuals and nurse-physician communications regarding ongoing care and follow up care upon return of individuals from outside hospitalization.
i) ASH has yet to make progress in the current incident and risk management systems. The facility needs to revise current processes, including identification of triggers and thresholds regarding high risk behavior, establishment of levels of interventions corresponding to the level of risk and appropriate notification and follow up mechanisms. The interventions and follow up should include, but not be limited, to the following:
    - First-level response by the WRPTs, including timely review of incidents and analysis of contributing factors, timely and appropriate use of Stat and PRN medications, judicious use of restrictive interventions in accord with current DMH procedures and use of positive behavior supports whenever indicated as well as other corrective actions, as needed;
    - Second-level review by clinical leadership;
    - Outside consultations, if necessary; and
    - An oversight mechanism to review trends and patterns and initiate systemic performance improvement projects.
j) The DMH needs to finalize efforts to automate the processes of assessments and WRPs.
k) Given that the EP provides the basis for the mental health services delivered in the California DMH State Hospitals, it is the monitor's recommendation that the DMH seriously consider standardizing across all hospitals the Administrative Directives that impact these services.
l) Functional/clinical outcomes of the current structural changes have yet to be identified and implemented to guide further implementation.
m) A well-functioning PSR Mall that meets the specific needs of the individuals is the centerpiece of the Wellness and Recovery Planning model. Progress remains to be made towards this goal, specifically in the areas of:
    i. Mall hours: The number of hours of Psychosocial Rehabilitation Mall (PSR) services (i.e., group facilitation or individual therapy) provided by the various disciplines, administrative staff, and others is currently minimal. The following table provides the minimum average number of hours of mall services that DMH facilities should provide:

DMH PSR MALL HOURS REQUIREMENTS

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
Before 8am: Supplemental Activities	Before 8am: Supplemental Activities	Before 8am: Supplemental Activities	Before 8am: Supplemental Activities	Before 8am: Supplemental Activities	Supplemental Activities	Supplemental Activities
8am – 6pm: Active Treatment Official Mall Hours: Groups A: Morning group B: Morning group LUNCH C: Afternoon group D: Afternoon group Individual Therapy Non-ABCD hours	8am – 6pm: Active Treatment Official Mall Hours: Groups A: Morning group B: Morning group LUNCH C: Afternoon group D: Afternoon group Individual Therapy Non-ABCD hours	8am – 6pm: Active Treatment Official Mall Hours: Groups A: Morning group B: Morning group LUNCH C: Afternoon group D: Afternoon group Individual Therapy Non-ABCD hours	8am – 6pm: Active Treatment Official Mall Hours: Groups A: Morning group B: Morning group LUNCH C: Afternoon group D: Afternoon group Individual Therapy Non-ABCD hours	8am – 6pm: Active Treatment Official Mall Hours: Groups A: Morning group B: Morning group LUNCH C: Afternoon group D: Afternoon group Individual Therapy Non-ABCD hours		
After 6pm: Supplemental Activities	After 6pm: Supplemental Activities	After 6pm: Supplemental Activities	After 6pm: Supplemental Activities	After 6pm: Supplemental Activities		

Required PSR MALL Hours as Facilitators or Co-Facilitators		
	Admissions Staff	Long-Term Staff
Psychiatry	4	8
Psychology	5	10
SW	5	10
RT	7	15
RN	6	12
PT	6	12
FTE Mall staff	20 hours as mall group facilitator	
Other hospital staff	As determined locally at each hospital	

The Long-Term staff Mall hours are also specified in the DMH Long Term Care Services Division Strategic Plan FY 2007-2009. The hours have been reduced for the Admissions clinical staff because of the heavy assessment workload and increased number of Wellness and Recovery Planning Conferences (WRPCs) that are held during the first 60 days of admission. There is no reduction in the required 20 hours of mall services provided to the individuals.

It is expected that during fixed mall hours, the Program/Units will be closed and all unit and clinical staff will provide services at the PSR Mall. Each hospital should develop and implement an Administrative Directive (AD) regarding the provision of emergency or temporary medical care during mall hours.

ii. **Progress notes**: ASH has yet to implement a requirement for providers of mall groups and individual therapy to complete and make available to each individual's Wellness and Recovery Planning Team (WRPT) the DMH-approved PSR Mall Facilitator Monthly Progress Note prior to regularly scheduled WRPCs. Without the information in the monthly progress notes, the WRPT has almost no basis for revising an individual's objectives and interventions. This is not aligned with the requirements as stated in the DMH WRP Manual. All hospitals must fully implement the PSR Mall Facilitator Monthly Progress Note in their PSR Malls for all groups and individual therapies.

iii. **Cognitive screening for PSR Mall groups**: PSR Mall groups should be presented in terms of the cognitive levels of the individuals at the hospital. Individuals can be stratified at three cognitive levels: (a) advanced (above average), (b) average, and (c) challenged (below average). A cognitive screening protocol, utilizing generally accepted testing methods, can be used to determine these levels for those individuals whose primary or preferred language is English.

The cognitive screening protocol will also provide information for the WRPT psychologist to determine whether a referral

to the DCAT and/or neuropsychological service is required. All State hospitals must ensure that cognitive screening has been completed for all individuals and that their Mall groups are aligned with their cognitive levels.

iv. **PSR Mall, Vocational Services and Central Program Services (CPS)**: The DMH facilities have made some progress toward developing a centralized PSR Mall service under the direction of the PSR Mall Director. However, not all services have been incorporated in the PSR Mall system, e.g., vocational services and CPS. All facilities must ensure that there is a single unified PSR Mall system that incorporates all psychosocial rehabilitation services that are included in the individuals' WRPs.

v. **Virtual PSR Mall**: Those facilities that have individuals who are civilly committed, and who have no legal barriers to attending rehabilitation and skills training groups in the community, should provide those individuals with that opportunity. These groups should be included as a part of a virtual PSR Mall. The WRPs of these individuals should include specific reference to community PSR Mall groups in the interventions. All facilities must ensure that this service is available to this group of individuals.

4. Staffing

The staffing table below shows the staffing pattern at ASH as of March 1, 2008. These data were provided by the facility. The table shows that there continues to be shortages of staff in several key areas: senior and staff psychiatrists, senior psychologists, pharmacy personnel, social workers, rehabilitation therapists, nursing staff (registered nurses and psychiatric technicians), special investigators, dieticians, lab technicians and health records technicians. ASH has made progress in recruitment of staff psychiatrists since the last review, but more work is needed to fill all required positions.

Atascadero State Hospital Vacancy Totals as of 3/1/2008

Identified Clinical Positions	Budgeted Positions 07/08 FY	Filled Positions	Vacancies	Vacancy Rate
Assistant Coordinator of Nursing Services	1	1	0	0.00%
Assistant Director of Dietetics	3	3	0	0.00%
Audiologist I	0	0	0	0.00%
Chief Dentist, CF	1	1	0	0.00%
Chief Physician & Surgeon, CF	1	1	0	0.00%

Atascadero State Hospital Vacancy Totals as of 3/1/2008				
Identified Clinical Positions	**Budgeted Positions 07/08 FY**	**Filled Positions**	**Vacancies**	**Vacancy Rate**
Chief Central Program Services	1	1	0	0.00%
Chief of Police Services & Security	1	1	0	0.00%
Clinical Dietician	11.4	8.6	2.8	24.56%
Clinical Laboratory Technologist (Safety)	4.5	3	1.5	33.33%
Clinical Social Worker (Health Facility/S)	71.7	47.5	24.2	33.75%
Communications Supervisor	1	1	0	0.00%
Communications Operator	9	9	0	0.00%
Coordinator of Nursing Services	1	1	0	0.00%
Coordinator of Volunteer Services	1	1	0	0.00%
Dental Assistant D/MH & DS	3	3	0	0.00%
Dentist, D/MH & DS	1	1	0	0.00%
Dietetic Technician (Safety)	3	3	0	0.00%
E.E.G. Technician (Psych Tech)	1	1	0	0.00%
Food Service Technician I	58.5	47.5	11	18.80%
Food Service Technician II	33	24	9	27.27%
Hospital Police Officers	113.8	93	20.8	18.28%
Hospital Police Sergeant	15	12	3	20.00%
Hospital Police Lieutenant	4	4	0	0.00%
Hospital Worker	0	0	0	0.00%
Health Record Technician	7.3	5	2.3	31.51%
Health Record Technician II (Spec)	3	3	0	0.00%
Health Record Technician II (Supv)	1	1	0	0.00%

Atascadero State Hospital Vacancy Totals as of 3/1/2008				
Identified Clinical Positions	**Budgeted Positions 07/08 FY**	**Filled Positions**	**Vacancies**	**Vacancy Rate**
Health Record Technician III	1	0	1	100.00%
Health Services Specialist (Safety)	26	25	1	3.85%
Institutional Artist Facilitator	1	1	0	0.00%
Licensed Vocational Nurse (Safety)	2	1	1	50.00%
Medical Technical Assistant	0	0	0	0.00%
Medical Transcriber	12	11	1	8.33%
Nurse Instructor	9	8	1	11.11%
Nurse Practitioner (Safety)	20	19	1	5.00%
Nursing Coordinator (Safety)	7	8	-1	-14.29%
Office Technician	57.3	51.3	6	10.47%
Pathologist	0	0	0	0.00%
Pharmacist I, D/MH & DS	14	8.6	5.4	38.57%
Pharmacist II	2	1	1	50.00%
Pharmacy Services Manager	1	0	1	100.00%
Pharmacy Technician, D/MH & DS	15	14	1	6.67%
Physician & Surgeon (Safety)	12	11	1	8.33%
Podiatrist D/MH & DS	0	0	0	0.00%
Pre-licensed Pharmacist	0	0	0	0.00%
Pre-licensed Psychiatric Technician (Safety)	40	40	0	0.00%
Pre-Registered Clinical Dietician	0	0	0	0.00%
Pre-Registered Nurse (D/MD & DS)	0	0	0	0.00%
Program Assistant (Mental Dis-Safety)	8	7	1	12.50%

Atascadero State Hospital Vacancy Totals as of 3/1/2008				
Identified Clinical Positions	**Budgeted Positions 07/08 FY**	**Filled Positions**	**Vacancies**	**Vacancy Rate**
Program Consultant (Psychology)	0	0	0	0.00%
Program Consultant (Rehab. Therapy)	1	1	0	0.00%
Program Consultant (Social Work)	1	0	1	100.00%
Program Director (Mental Dis. - Safety)	7	7	0	0.00%
Psychiatric Nursing Education Director	1	1	0	0.00%
Psychiatric Technician (Safety)	496.6	456.5	40.1	8.07%
Psychiatric Technician Trainee (Safety)	75	50.3	24.7	32.93%
Psychiatric Technician Assistant (Safety)	14	9	5	35.71%
Psychiatric Technician Instructor	2	2	0	0.00%
Psychologist-HF, Clinical (Safety)	47.3	35	12.3	26.00%
Public Health Nurse I (D/MH &DS)	1	1	0	0.00%
Public Health Nurse II	2	2	0	0.00%
Radiologic Technologist	0	0	0	0.00%
Registered Nurse (Safety)	298.1	196.8	101.3	33.98%
Rehabilitation Therapist S.F., Art-Safety	1	1	0	0.00%
Rehabilitation Therapist S.F., Dance-Safety	2	1	1	50.00%
Rehabilitation Therapist S.F., Music-Safety	14	11	3	21.43%
Rehabilitation Therapist S.F., Occup-Safety	1	0	1	100.00%
Rehabilitation Therapist S.F., Rec.-Safety	49.8	23.5	26.3	52.81%
Senior Psychiatrist (Specialist)	4.6	1	3.6	78.26%
Senior Psychiatrist, CF, (Supervisor)	2	2	0	0.00%
Senior Psychologist, H.F. (Specialist)	4	3	1	25.00%

Atascadero State Hospital Vacancy Totals as of 3/1/2008				
Identified Clinical Positions	**Budgeted Positions 07/08 FY**	**Filled Positions**	**Vacancies**	**Vacancy Rate**
Senior Psychologist, C.F. (Supervisor)	6	6	0	0.00%
Senior Psychiatric Technician (Safety)	109	87	22	20.18%
Sr. Radiologic Technologist(Specialist-Safety)	1	1	0	0.00%
Senior Special Investigator I, D/MH & DS	1	0	1	100.00%
Senior Vocational Rehab Counselor	2	2	0	0.00%
Special Investigator I, D/MH & DS	2	0	2	100.00%
Speech Pathologist I D/MH & DS	0	0	0	0.00%
Staff Psychiatrist (Safety)	76.9	18.5	58.4	75.94%
Supervising Registered Nurse (Safety)	2	2	0	0.00%
Teacher-Adult Educ.	29.9	8	21.9	73.24%
Teaching Assistant	7	7	0	0.00%
Unit Supervisor (Safety)	33	32	1	3.03%
Vocational Services Instructor	4	3	1	25.00%
Vocational Rehabilitation Counselor	0	0	0	0.00%

In order to meet the Enhancement Plan requirements, the overall numbers of nursing staff must increase and the skill mix must be expanded. The facility needs sufficient numbers of direct service nursing staff to provide a minimum of 5.5 nursing care hours per patient day (NCHPPD) on all units. If any individual on the unit is on 1:1 observation, an additional staff member should be added to each shift for the period of time an individual is on 1:1 observation, and this additional staff member would not be counted in the overall NCHPPD.

In order to ensure sufficient Registered Nurses to fulfill the requirements of the Enhancement Plan, the nursing staff skill mix should be 35-40% RNs and 60-65% Psychiatric Technicians and/or LVNs. Additionally, there should be a sufficient number of nursing educators, supervisors, and administrators, who should not be included in the calculation of NCHPPD, to ensure that generally accepted professional standards of psychiatric mental health nursing care are fully met.

Psychiatric Mental Health Advanced Practice Nurses and/or Clinical Nurse Specialists should be actively recruited to develop a program and provide education for psychiatric mental health nursing. Within the first 90 days of employment, any nurse who does not have previous experience in psychiatric mental health nursing should be required to complete a basic psychiatric mental health nursing review course.

Finally, there is a shortage of hospital police officers and Special Investigators across DMH facilities. This shortage compromises the timeliness of the practices and procedures required for compliance with Section I of the Enhancement Plan. Salary appears to be the key reason that the facilities have not been able to recruit additional staff and have lost staff to the Corrections Department and local communities, despite DMH's vigorous recruitment and training efforts. This situation is serious and must be reversed to achieve compliance.

E. Monitor's Evaluation of Compliance

The status of compliance is assessed considering the following factors:

1. An objective review of the facility's data and records;
2. Observations of individuals, staff and service delivery processes;
3. Interviews with individuals, staff, facility and State administrative and clinical leaders;
4. An assessment of the stability of the facility's current structure and functions in terms of potential for self-sustenance in order adequately meet the needs of individuals currently and in the future;
5. Assessment of trends and patterns of change rather than single and/or temporary occurrences of compliance or noncompliance that are inconsistent with these patterns and trends;
6. When no instance requiring implementation of a specific requirement was found in the baseline assessment, the compliance was rated as Not Applicable for this evaluation.
7. PSH and ASH have each attained substantial compliance in one section of the EP. Once a hospital reaches substantial or full compliance in a section of the EP, the CM begins maintenance evaluation of that section for 18 consecutive months. If the hospital maintains substantial or full compliance during the 18-month period, the CM's evaluation of that section will cease, and it will be up to DMH to provide oversight evaluation and ensure future maintenance. Thus, DMH should be prepared to assume this responsibility in terms of trained personnel as each section of the EP achieves maintenance status at each hospital.

F. Next Steps

1. The Court Monitor's team is scheduled to tour Atascadero State Hospital October 20 to 24, 2008.for a follow-up evaluation.
2. The Court Monitor's team is scheduled to reevaluate Patton State Hospital June 9 to 13, 2008.
3. All compliance reports should be reviewed and utilized, as applicable, by all facilities to guide implementation efforts regardless of the schedule of facility-specific assessments.

C. Integrated Therapeutic and Rehabilitation Services Planning		
	Each State hospital shall provide coordinated, comprehensive, individualized protections, services, supports, and treatments (collectively "therapeutic and rehabilitation services") for the individuals it serves, consistent with generally accepted professional standards of care. In addition to implementing the therapeutic and rehabilitation planning provisions set forth below, each State hospital shall establish and implement standards, policies, and practices to ensure that therapeutic and rehabilitation service determinations are consistently made by an interdisciplinary team through integrated therapeutic and rehabilitation service planning and embodied in a single, integrated therapeutic and rehabilitation service plan.	**Summary of Progress:** 1. ASH has strengthened its WRP training, including the appointment of a Master Trainer, the assignment of WRPT mentors and initiation of training based on the MSH Modules. 2. ASH has improved the WRPC process. 3. ASH has recently initiated a process of review and analysis of the internal monitoring data by the facility's Quality Council. 4. ASH has improved the staffing ratios in all admission units (except for RTs). 5. ASH has improved Mall Group offerings and lesson plans. 6. ASH has implemented the DMH standardized tools in all applicable sections (C.1 and C.2). 7. ASH has improved the content of case formulations in many WRPs. 8. ASH has increased the number of active treatment hours for individuals in its care.
1. Interdisciplinary Teams		
C.1	The interdisciplinary team's membership shall be dictated by the particular needs and strengths of the individual in the team's care. At a minimum, each State Hospital shall ensure that the team shall:	**Methodology:** <u>Interviewed</u>: 1. Martha Staib, Treatment Enhancement Coordinator 2. Donna Nelson, Standards Compliance Director <u>Reviewed</u>: 1. ASH database regarding WRP training competency by program 2. ASH Lesson Title: The Wellness and Recovery Plan Manual 3. WRP Knowledge Assessment Post-Test 4. ASH data regarding number and percentages of staff completing WRP training 5. DMH WRP Process Observation Monitoring Form

		6. DMH WRP Process Observation Monitoring Form Instructions 7. ASH WRP Process Observation Monitoring summary data (October 2007 to February 2008) 8. DMH Clinical Chart Auditing Form 9. DMH Clinical Chart Auditing Form Instructions 10. ASH Clinical Chart Auditing Form summary data (October 2007 to February 2008) 11. DMH WRP Psychiatry Team Leadership Monitoring Form 12. DMH WRP Psychiatry Team Leadership Monitoring Form Instructions 13. ASH WRP Psychiatry Team Leadership summary data (January and February 2008) 14. ASH data regarding average length of stay on the admissions units 15. ASH data regarding staffing ratios <u>Observed</u>: 1. WRPC (Program IV, Unit 6B) for 7-day review of JLB 2. WRPC (Program IV, Unit 9A) for 7-day review (transfer) of MG 3. WRPC (Program IV, Unit 6B) for 14-day review of COP 4. WRPC (Program IV, Unit 2) for monthly review of DC 5. WRPC (Program IV, Unit 2) for monthly review of DLI 6. WRPC (Program IV, Unit 9B) for monthly review of JBF 7. WRPC (Program II, Unit 25) for quarterly review of JDM 8. WRPC (Program I, Unit 17A) for quarterly review of RPP
C.1.a	Have as its primary objective the provision of individualized, integrated therapeutic and rehabilitation services that optimize the individual's recovery and ability to sustain himself/herself in the most integrated, appropriate setting based on the individual's strengths and functional and legal status and support the individual's ability to exercise his/her	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Implement the revised DMH WRP Manual in all programs at ASH. **Findings:** ASH has implemented the WaRMSS WRP module across the hospital. However, the facility has modified its initial schedule for

<table>
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<td>liberty interests, including the interests of self determination and independence.</td>
<td>implementation of the DMH WRP Manual. The main reason for modifying this schedule was an administrative decision to increase in the number of admission units to six. The increase in the number of admission units was necessary to accommodate the rate of new admissions to the facility and to fully implement the WRP model in all admission units prior to facility-wide implementation. Since the last review period, the facility has added three admission units (Unit 8 as of October 2007, Unit 23 as of January 2008 and Unit 21 as of March 2008). The following is the facility's updated implementation schedule:

<table>
<tr><th>Program</th><th>Roll-out date</th></tr>
<tr><td>I</td><td>August 2008</td></tr>
<tr><td>II</td><td>July 2008</td></tr>
<tr><td>III</td><td>May 2008</td></tr>
<tr><td>IV</td><td>August 2007</td></tr>
<tr><td>V</td><td>March 2008</td></tr>
<tr><td>VI</td><td>April 2008</td></tr>
<tr><td>VII</td><td>June 2008</td></tr>
</table>

Recommendation 2, October 2007:
Continue and strengthen current WRP training program. In particular, the facility needs to ensure that each program has a dedicated trainer, to build the competency of program trainers and to provide ongoing mentoring for all members of the WRPTs.

Findings:
The following outlines the facility's status since the last report:

1. ASH has continued to provide the three-hour overview WRP training.
2. Since November 2007, ASH has extended the overview training to include RNs and PTs, with the goal of providing this training to all clinical staff by June 2008.</td>
</tr>
</table>

		3. ASH has assigned Jan Alarcon, PhD as Master WRP Trainer for the hospital (in November 2007). 4. The State Consultant, Dr. Ronald Boggio, trained 14 new WRP mentors in November 2007. Dr. Boggio returns to ASH on a monthly basis to monitor the progress of the mentors and the teams they are mentoring. 5. At this time, 14 teams have mentors, and twenty-five teams do not. Seventeen additional mentors are scheduled to receive training in May 2008. 6. Mentors are currently assigned to all teams on Program IV and to all admission teams in the facility. These teams receive weekly mentoring. 7. The Master WRP Trainer, Dr. Alarcon, initiated training on the five MSH modules for all clinicians on Programs IV, V, and VI. Additionally, Dr. Alarcon developed an addendum, including a worksheet, to the Case Formulation Module. The Worksheet was piloted with the mentors. The plan is to provide this additional training to all clinicians. 8. Since November 2007, ASH has provided the WRP Overview Training to Level of Care Staff (PTs and RNs). 9. ASH has displayed posters regarding the WRP process and content in all team rooms to assist in improving the quality of the WRPCs. 10. ASH has implemented a process to provide the WRPTs with team-specific summary data from the Clinical Chart Auditing and WRP Process Observation Forms so that improvement efforts can be better targeted. 11. ASH has organized a Wellness and Recovery Enhancement Plan Performance Improvement Team (EPPI). In recent weeks, the facility began a process of weekly review of internal monitoring data by the facility's Quality Council to assess status of implementation and ensure that the data are used to inform practice.

Recommendation 3, October 2007:
Provide data regarding competency-based training of WRPT members in all phases of training.

Findings:
The facility reported data regarding the number and percentages of WRPT staff who have completed the overview three-hour training and met the required threshold of competency (score of 95% on the post-test). The data showed a positive trend during this review period. The following table outlines the facility's data regarding the percentages of WRPT members who were trained to competency in February 2008:

Hospital-wide % Team Members Trained by Discipline	
MD	91%
PhD	96%
SW	90%
RT	97%
RN	59%
PT	51%

Recommendations 4 and 5, October 2007:
- Monitor this requirement based on a 20% sample and provide data analysis and corrective actions regarding areas of low compliance.
- Address and correct factors related to low compliance.

Findings:
ASH used the DMH Clinical Chart Auditing Form to assess compliance (October 2007 to February 2008) in Program IV. The average sample was 81% of the monthly, quarterly and annual WRPCs due on Program IV. Due to the small number of each type of conference, the data are presented in an aggregate form. The mean compliance rates for each indicator are presented in relevant cells in C.2.

		Other findings: The monitor attended eight WRPCs. In general, the meetings showed progress in the overall process of the team meetings. The following are examples of areas of progress: 1. All meetings started on time. 2. The team psychiatrists/Psychiatric Nurse Practitioners assumed leadership of all meetings attended. 3. The teams presented a summary of the assessment data and reviewed risk factors prior to the individual's arrival. 4. The teams discussed the key questions to be addressed during the individual's' presence. 5. The team members were respectful of the individuals and made an effort to elicit their input. 6. The teams reviewed the diagnosis, objectives and interventions with the individual. 7. In general, the teams updated the individual's life goals and strengths during the meeting. 8. The teams made an effort to review the individual's attendance and participation at the assigned groups. 9. In general, the teams reviewed the By Choice participation and point allocation with the individual. However, the meetings showed the following pattern of process deficiencies: 1. In some meetings, required core members representing nursing and social work were not present. 2. The teams did not consistently update the present status section to reflect the status of the individual in all required domains. 3. The teams did not consistently review the Task Tracking Form. 4. The teams did not link the individual's life goals and strengths with

		the WRP objectives and interventions. 5. There was no mechanism to conduct data-based review of the individual's progress in Mall groups and to ensure that Mall offerings are properly linked to the WRP objectives.. 6. The reviews of the individual's progress towards discharge criteria were either generic or did not occur, and the teams did not consistently discuss progress needed to meet each criterion with the individual. **Compliance:** Partial. **Current recommendations**: 1. Provide a summary outline of all WRP training and mentoring provided to the WRPTs during the reporting period. 2. Provide a summary outline of any improvements in practice made as a result of review by the Quality Council of internal monitoring data. 3. Provide documentation of the number and percentage of WRPT members completing the three-hour overview training and training on the specific five modules in Program IV and hospital-wide.
C.1.b	Be led by a clinical professional who is involved in the care of the individual.	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Monitor both presence and proper participation by the team leaders in all WRP meetings. **Findings:** ASH used the DMH WRP Psychiatry Team Leadership Monitoring Form to assess compliance (January and February 2008). The data were based on two observations per unit team by senior supervising psychiatrists per month. The following are the monitoring indicators and corresponding mean compliance rates:

1.	*Psychiatrist was present.*	100%
2.	*Psychiatrist elicited the participation of all disciplines.*	100%
3.	*Psychiatrist ensured the (integration of) assessments from other disciplines into the case formulation.*	83%
4.	*Psychiatrist ensured the "Present Status" section in the Case Formulation was updated.*	65%
5.	*Psychiatrist ensured that the interventions were linked to the measurable objectives.*	52%
6.	*Psychiatrist ensured the individual participated in the treatment, rehabilitation and enrichment activities which are goal-directed, individualized and based on a thorough knowledge of the individual's psychosocial history and previous response.*	100%

ASH also used the DMH WRP Process Observation Monitoring Form to assess compliance (October 2007 to February 2008). The data were based on an average sample of 59% of the 7-day, 14-day, monthly, quarterly and annual WRPCs on Program IV. The overall compliance rate was 3%. Data analysis showed that the facility had 95% compliance with the requirement that the team member leading the WRPC was a core member of the WRPT, but 3% compliance with the sub-indicator regarding this person being the identified facilitator for the team.

Recommendation 2, October 2007:
Implement a peer mentoring system to ensure competency in team leadership skills.

Findings:
ASH reported that the WRP Master Trainer, working with a psychiatry representative, has provided five training sessions to the Psychiatry Department to address the process of peer mentoring in Wellness and Recovery Planning, including team leadership skills. The facility has

		initiated a process of peer mentoring by seven senior psychiatrists (one for each program) as of February 2008. This process included training and feedback on team leadership. **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using the WRP Process Observation and Team Leadership Monitoring Forms based on 20% and 100% samples, respectively. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
C.1.c	Function in an interdisciplinary fashion.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Same as in C.1.a and C.1.b. **Findings:** Same as in C.1.a and C.1.b. **Other findings:** ASH used the WRP Observation Monitoring Form to assess compliance (October 2007 to February 2008). The average sample was 59% of the 7-day, 14-day, Monthly, quarterly and annual WRPCs on program IV. The mean compliance rate was 1%. However, a breakdown of the facility's data showed variable compliance rates with the sub-criteria of this indicator (all sub-criteria must be met for root question to be in compliance):

		<table><tr><td>1.</td><td>*The core team members participate by presenting or updating discipline-specific and/or holistic assessment data.*</td><td>9%</td></tr><tr><td>2.</td><td>*The teams reviews and updates the DMH WRPC Task Tracking Form.*</td><td>61%</td></tr><tr><td>3.</td><td>*Team members present their assessments and consultations as listed in the Task Tracking Form.*</td><td>35%</td></tr><tr><td>4.</td><td>*Team members discuss the individual's specific outcomes for the WRP review period.*</td><td>3%</td></tr></table> **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using process observation based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
C.1.d	Assume primary responsibility for the individual's therapeutic and rehabilitation services, and ensure the provision of competent, necessary, and appropriate psychiatric and medical care.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Same as in C.1.a, C.1.b and C.1.c. **Findings:** Same as in C.1.a, C.1.b and C.1.c. **Other findings:** ASH used the DMH Clinical Chart Audit Form to assess compliance (October 2007 to February 2008). The facility reviewed an average sample of 81% and found a mean compliance rate of 1%. This rate was

<table>
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<td>calculated based on compliance rates of 2% with the following sub-items:

<table>
<tr><td>1.</td><td>The present status and previous response to treatment sections of the case formulation are aligned with the assessments; and</td></tr>
<tr><td>2.</td><td>A review of assessments, WRP and WRP attachments indicate that the information in the WRP is supported by the assessments and DMH PSR Mall Facilitator Monthly Progress Notes.</td></tr>
</table>

The plan of improvement included training of additional mentors to ensure a dedicated mentor for each team, further training using the MSH Modules and ASH supplements and full implementation of the WaRMSS.

Compliance:
Partial.

Current recommendations:
1. Monitor this requirement using the Clinical Chart Audit form based on at least a 20% sample.
2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</td>
</tr>
<tr>
<td>C.1.e</td>
<td>Ensure that each member of the team participates appropriately in competently and knowledgeably assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising the therapeutic and rehabilitation services.</td>
<td>Current findings on previous recommendations:

Recommendation 1, October 2007:
Improve clinical oversight to ensure competency in the processes of assessments, reassessments, interdisciplinary team functions and proper development and timely and proper updates of case formulations, foci of hospitalization, objectives and interventions.</td>
</tr>
</table>

Findings:
As of February 2008, ASH has assigned seven senior psychiatrists, one per program, to provide supervision of the staff psychiatrists on their units. The facility also assigned one supervising rehabilitation therapist, one supervising psychologist and one supervising social worker to provide clinical oversight on Programs IV and V.

Recommendation 2, October 2007:
Monitor this requirement and analyze and correct factors related to low compliance.

Findings:
ASH used the previously mentioned DMH WRP Observation Monitoring Form to assess compliance (October 2007 to February 2008). The mean compliance rate was 0%. However, a breakdown of the data showed variable rates with sub-items of this tool as follows:

1.	*Each team member presents relevant and appropriate content for the discipline-specific assessments. The Psychiatric Technician presents global observations of the individual for the WRP review period.*	6%
2.	*Team members present their assessments and consultations as listed in the Task Tracking Form.*	29%
3.	*Team members discuss the individual's specific outcomes for the WRP review period.*	2%

Compliance:
Partial.

Current recommendations:
1. Monitor this requirement using process observation based on at least a 20% sample.

		2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
C.1.f	Ensure that assessment results and, as clinically relevant, consultation results, are communicated to the team members, along with the implications of those results for diagnosis, therapy and rehabilitation by no later than the next review.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Same as in C.1.a through C.1.e. **Findings:** Same as in C.1.a through C.1.e. **Other findings:** ASH used the DMH WRP Observation Monitoring Form to assess compliance (October 2007 to February 2008). The mean compliance rate was 0%. The facility reported that this rate was mistakenly based on three sub-criteria that needed to be answered yes for the root question to be in compliance. Beginning in March 2008, this error will be corrected and the facility anticipates that this change will result in a much higher compliance rate in the future. **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using process observation based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
C.1.g	Be responsible for the scheduling and coordination of assessments and team meetings, the drafting of	**Current findings on previous recommendations:**

<table>
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<td>integrated treatment plans, and the scheduling and coordination of necessary progress reviews.</td>
<td>
Recommendations 1 and 2, October 2007:
• Continue to monitor this requirement using process observation.
• Address and correct factors related to low compliance.

Findings:
ASH used the DMH WRP Observation Monitoring Form to assess compliance (October 2007 to February 2008). The mean compliance rate was 34%. A breakdown of the data showed variable rates with sub-items of this tool as follows:

<table>
<tr><td>1.</td><td>There is an identified WRP recorder who is responsible for the scheduling and coordination of assessments and WRPCs. This person typically records the WRP. If all team members record at the conference there should still be one identified person for finalizing the WRP and obtaining the necessary signatures at the end of the WRPC.</td><td>84%</td></tr>
<tr><td>2.</td><td>The identified WRP recorder (performs other tasks)</td><td>39%</td></tr>
</table>

The facility presented a plan to improve compliance utilizing the team mentors and the hospital-wide Team Recorder workgroup meetings and trainings.

Compliance:
Partial.

Current recommendations:
1. Monitor this requirement using process observation based on at least a 20% sample.
2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
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<td>C.1.h</td>
<td>Consist of a stable core of members, including at least the individual served; the treating psychiatrist, treating psychologist, treating rehabilitation therapist, the treating social worker; registered nurse and psychiatric technician who know the individual best; and one of the individual's teachers (for school-age individuals), and, as appropriate, the individual's family, guardian, advocates, attorneys, and the pharmacist and other staff.</td>
<td>
Current findings on previous recommendations:

Recommendations 1 and 2, October 2007:
• Develop and implement a database that includes information regarding the core membership of all teams in the facility.
• Regularly monitor the attendance by core members, including the individuals, in the WRPCs.

Findings:
ASH has implemented these recommendations. Since the last review, the facility has developed a Clinical Roster to calculate the number of fully and partially staffed WRPTs hospital-wide on a monthly basis and a WRP Spreadsheet to track training information on core members of the WRPTs. In addition, ASH used the DMH Observation Monitoring Form to assess compliance (October 2007 to February 2008). The following table outlines the mean compliance rates regarding attendance by the individual and representatives of different core disciplines in the WRPCs, based on a review of a 63% mean sample of the WRPCs due per month:

<table>
<tr><th>Individual/Discipline</th><th>%C</th></tr>
<tr><td>Individual</td><td>95</td></tr>
<tr><td>MDs</td><td>94</td></tr>
<tr><td>PhDs</td><td>80</td></tr>
<tr><td>SWs</td><td>78</td></tr>
<tr><td>RTs</td><td>77</td></tr>
<tr><td>RNs</td><td>75</td></tr>
<tr><td>PTs</td><td>22</td></tr>
</table>

The data showed inadequate representation by psychology, social work, rehabilitation therapy, nursing, and Psych Techs (PTs) at the WRPCs, with the lowest attendance by PTs. The facility reported the following two main factors for the low attendance by these disciplines:
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</table>

		1. The facility had an 11% vacancy rate in the nursing disciplines. 2. The PTs have historically not been recognized as core team members. **Recommendation 3, October 2007:** Address and correct the deficiencies regarding core membership and attendance by core members. **Findings:** ASH reported that in October 2007, the facility had eight admission teams, seven of which were fully staffed with core team members, and 26 non-admission teams, 13 of which were fully staffed. As presented in this monitor's previous report, the data showed that hospital-wide, the missing core members as of October 2007 were four MDs, 22 PhDs, three SWs and eight RTs. By March 2008, ASH increased the admission teams to 12, all of which were fully staffed except for one MD. The facility continues to have 26 non-admission teams, ten of which are fully staffed. Since the last review period, the facility has filled three MD, seven PhD, two SW and three RT team vacancies. The facility still has vacancies, but is missing fewer core members now than in October 2007. ASH presented a plan to improve recruitment of needed disciplines and to track team vacancies and staff attendance. **Compliance:** Partial. **Current recommendations**: 1. Continue current efforts to improve attendance by core members. 2. Monitor this requirement using process observation based on at least a 20% sample.

<table>
<tr><td></td><td></td><td>3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).
4. Recruit sufficient staff to fill current vacancies in core WRPT members.</td></tr>
<tr><td>C.1.i</td><td>Not include any core treatment team members with a case load exceeding 1:15 in admission teams (new admissions of 90 days or less) and, on average, 1:25 in all other teams at any point in time.</td><td>Current findings on previous recommendation:

Recommendation 1, October 2007:
Same as in C.1.h.

Findings:
Same as in C.1.h.

Recommendation 2, October 2007:
Ensure that individuals remain on the admission units for up to 90 days prior to inter-unit transfer, if needed.

Findings:
ASH presented data regarding the average length of stay on the admissions units since the last review. The data showed an increase in the average length of stay from 23.5 days in October 2007 to 32.2 days in February 2008.

Other findings:
The following tables summarize the facility's data regarding staffing ratios in admission and non-admission units. The data identify the mean staff/individual ratios during this review period.

<table>
<tr><td></td><td colspan="2">Ratio of individuals/staff members</td></tr>
<tr><td></td><td>Admission units</td><td>Non-admissions units</td></tr>
<tr><td>MD</td><td>1:11</td><td>1:26</td></tr>
<tr><td>PhD</td><td>1:13</td><td>1:80</td></tr>
</table>
</td></tr>
</table>

		<table><tr><td>CSW</td><td>1:13</td><td>1:27</td></tr><tr><td>RT</td><td>1:19</td><td>1:36</td></tr><tr><td>RN</td><td>1:5</td><td>1:10</td></tr><tr><td>PT</td><td>1:4</td><td>1:5</td></tr></table> The data showed that the staffing ratios on the admissions units are in compliance except for RTs. The facility recognized the low compliance on the non-admission units and presented a plan to increase recruitment in an effort to achieve compliance by August 2008. **Compliance:** Partial. **Current recommendations**: 1. Same as in C.1.h. 2. Ensure that individuals remain on the admission units for up to 90 days prior to inter-unit transfer, if such transfer is needed.
C.1.j	Not include staff that is not verifiably competent in the development and implementation of interdisciplinary wellness and recovery plans.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Same as in C.1.a through C.1.f. **Findings:** Same as in C.1.a through C.1.f. **Compliance:** Partial. **Current recommendations**: Same as in C.1.a through C.1.f.

2. Integrated Therapeutic and Rehabilitation Service Planning (WRP)		
	Each State hospital shall develop and implement policies and protocols regarding the development of therapeutic and rehabilitation service plans, referred to as "Wellness and Recovery Plans" [WRP]) consistent with generally accepted professional standards of care, to ensure that:	**Methodology:** <u>Interviewed</u>: 1. Individuals TF and JC 2. Aener Gagnom, RN 3. Ai Fujimoto, Recreation Therapist, Basic Interpersonal Task Skills PSR Mall Group Co-Facilitator 4. Alice Dodge, LCSW, Social Work 5. Angela McGregor, Recreation Therapist, Arts and Crafts PSR Mall Group Facilitator 6. Brooke Hatcher, RT 7. Cameron Grant, ASH Police Officer 8. Carrie Dorsey, Music Therapist, Interacting Through Music PSR Mall Group Facilitator 9. Charlie Joslin, Clinical Administrator 10. Chris McDonald, PsyD, Admissions Psychologist 11. Cindy Duke, PhD, Neuropsychologist 12. Dante Karas, Assistant Mall Director 13. Dawn Hartman, Clinical Dietitian 14. Diane Imrem, PsyD, Chief of Psychology 15. Diane Walker, PhD, Psychologist, PBS Team Member 16. Don Johnson, PhD, Psychologist 17. Donna Nelson, Director, Standards Compliance 18. Elizabeth Price, Speech Language Pathologist (contract) 19. Erin Dengate, Assistant Director of Dietetic 20. George Caldwell, RN 21. Glen Potts, Ph.D., Psychologist, PBS Team Member 22. Heather Grigsby, Recreation Therapist, Gym PSR Mall Group Facilitator 23. Henry Ahlstrom, PhD, Psychologist 24. Howard Orozco, PT 25. Jan Alarcon, PhD, ASH Master WRP Trainer

		26. Janet McMillan, RN 27. Jeffrey Teuber, PhD, Senior Psychologist, PBS Team Leader 28. Joe DeBruin, PhD, Psychologist, Chair C-PAS 29. John De Morales, Executive Director 30. Joshua Goible, Recreation Therapist, Physical Wellness and Exercise PSR Mall Group Co-Facilitator 31. Karen Dubiel, Assistant to Clinical Administrator 32. Ladonna DeCou, Chief of Rehabilitation 33. Leslie Bolin, PhD, Neuropsychologist 34. Louis Santiago, SPT, BY CHOICE Coordinator 35. M. Marble, PT 36. Margarita Thomas, PT 37. Maria Ornelas, RN 38. Marie Diets-Strover, Special Education Teacher 39. Mark Ferris, Recreation Therapist, Competency Through Activities PSR Group Facilitator 40. Matthew Hennessy, PhD, Mall Director 41. Meg Benitez, Physical Therapist (contract) 42. Melissa Smet, PT 43. Monica Minugh 44. Nancy Sharpe, RN 45. Patrick Orourke, Unit Supervisor 46. Rachelle Rianda, Acting Supervising Rehabilitation Therapist 47. Rich Morey, PhD, Senior Psychologist 48. Roland Strauss, RT 49. Scott Cahil Stewart 50. Sherie Colleen, LCSW, Social Work 51. Tandy Williams, PhD, Psychologist 52. Terry Devine, Physical Therapist (contract) 53. Toby Coveria, RT <u>Reviewed</u>: 1. The charts of the following 188 individuals: AAD, ADG, ADS, AE,

		AF, AG, AH, AL, ALC, ALW, APL, ARC, ARM, ARR, AS, BF, BG, BPN, CBC, CBJ, CC, CDR, CE, CG-2, COH, CSR, CTS, CV, DAD, DAP, DAW, DD, DDD, DJB, DJS, DL, DLD, DLM, DMB, DRD, DRR, DRS, DS, DSA, EA, ECD, EI, EJ, EO, EVF, EVT, EW, FA, FGM, FRP, FW, GAW, GCD, GCJ, GD, GDC, GEG, GEP, GP, HK, HTK, JAG, JAM, JB, JC, JCA, JCB, JCS, JCT, JDP, JE, JEP, JES, JFD, JG, JH, JIL, JJ, JKC, JKS, JLB, JLF, JLP, JPM, JR, JRR, JRW, JSG, JSR, JT, JW, JWB, KAT, KBG, KLW, KNB, LAB, LAP, LGS, LH, LHJ, LPM, LRT, LSS, LT, LW, MA, MAC, MAG, MDH, MDW, MER, MEW, MG, MGM, MJC, MJG, MJP, MLT, MM, MR, MRM, MW, MWN, MWV, NMK, ODM, PCK, PG, PH, PMJ, PP, PRI, PVH, RAC, RCH, RD, RDN, RDS, RDW, RE, REC, RH, RJG, RJL, RKD, RLS, RLW, RPD, RRF, RS, RSA, RSP, RT, RW, SAA, SAJ, SB, SC, SCK, SEF, SLM, SR, SRB, SW, TAQ, TC, TDW, TE, TG, TH, THT, TLC, TLG, TSK, TSM, TWS, VL, WJW, WM, WST, WT and WTM 2. WRP Training Course Outline: Module I, Engagement, including case examples and post-test 3. WRP Training Course Outline: Module II, Case Formulation, including practice worksheet and post-test 4. WRP Training Course Outline: Module III, Foci and Objectives 5. WRP Training Course Outline: Module IV, Interventions and Mall Integration 6. WRP Training Course Outline: Module V, Discharge Planning 7. DMH WRP Process Observation Monitoring Form 8. DMH WRP Process Observation Monitoring Form Instructions 9. ASH WRP Process Observation Monitoring summary data (November 2007 to February 2008) 10. DMH Clinical Chart Auditing Form 11. DMH Clinical Chart Auditing Form Instructions 12. ASH Clinical Chart Auditing Form summary data (November 2007 to February 2008) 13. DMH WRP Substance Abuse Monitoring Form 14. DMH WRP Substance Abuse Monitoring Form Instructions

		15. ASH Substance Abuse Monitoring summary data (January and February 2008) 16. ASH MAPP data regarding active treatment hours scheduled and attended (September 2007 to February 2008) 17. ASH data regarding Introduction to Wellness and Recovery and Medication Management groups (September 2007 to February 2008) 18. ASH BMI List 19. ASH Mall Curriculum 20. ASH MAPP Roster Pathway 21. ASH PSR Mall Schedule 22. ASH Resource Library and Inventory Materials 23. ASH Scheduled Mall Hours List 24. ASH Scheduled Exercise Group List 25. BY CHOICE Monthly Fidelity Checks 26. Cognitive Disorders Diagnosed After Admission, last six months 27. DMH Integrated Assessment: Psychology Section 28. DMH Integrated Assessment: Rehabilitation Therapy Section 29. DMH Integrated Assessment: Social Work Section 30. List of New Supplemental Activities 31. Mall Alignment Monitoring Form 32. Mall Alignment Monitoring Form Instructions 33. Mall Enhancement Plan Performance Improvement (EPPI) 34. Mall Monthly Progress Note Pathway 35. Medical Appointment Scheduled/Cancelled List 36. PBS Behavioral Guidelines Integrity Check Lists 37. Recovery and Mall Services Procedural Manual 38. Substance Abuse Service Employee Competency Workbook 39. Unit Staff Mall Area Responsibilities 40. Wellness and Recovery Plan Manual 41. WRP Active Treatment Request 42. List of individuals who received Physical, and/or Speech Therapy direct treatment from September 2007-February 2008

		Observed: 1. WRPC (Program IV, Unit 6B) for 7-day review of JLB 2. WRPC (Program IV, Unit 9A) for 7-day review (transfer) of MG 3. WRPC (Program IV, Unit 6B) for 14-day review of COP 4. WRPC (Program IV, Unit 2) for monthly review of DC 5. WRPC (Program IV, Unit 2) for monthly review of DLI 6. WRPC (Program IV, Unit 9B) for monthly review of JBF 7. WRPC (Program II, Unit 25) for quarterly review of JDM 8. WRPC (Program I, Unit 17A) for quarterly review of RPP 9. WRPC (Program III, Unit 21) for review of CM 10. Mall group: Depression and Crisis Management 11. Mall group: Symptom Management 12. Mall group: Coping with Anxiety 13. Mall group: "Ready-Set-Go" 14. Mall group: Substance Abuse Recovery 15. Mall group: Social Skills Through Music
C.2.a	Individuals have substantive input into the therapeutic and rehabilitation service planning process, including but not limited to input as to mall groups and therapies appropriate to their WRP.	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Ensure that the current WRP training curriculum includes a module regarding the engagement of individuals. **Findings:** During this review period, ASH began training using the MSH training module on engagement and added to this module clinical examples that address ASH-specific legal commitments. **Recommendation 2, October 2007:** Implement a performance improvement process to address and correct factors related to low compliance with this requirement.

Findings:
Same as in C.1.a, Recommendation 2.

Other findings:
ASH used the DMH WRP Process Observation Monitoring Form (November 2007 to February 2008). The average sample was 63% of the WRPCs (7-day, 14-day, monthly, quarterly and annual) due on Program IV. Due to the limited number of each type of WRPC, the data are aggregated and the mean compliance rate was 6%. A breakdown of the facility's data showed variable compliance rates with the sub-criteria of this indicator (all sub-criteria must be met for the root question to be in compliance):

6.a	The WRPT asks the individual for his input into the evaluation of progress on each objective.	12%
6.b	When the individual has achieved an objective, at the current WRPC, the WRPT discusses with the individual the groups (and individual therapy, as appropriate) available for the next objective. The individual makes a choice from several equivalent options.	7%
6.c	The WRPT reviews the BY CHOICE points, preferences and allocation with the individual. The individual determines how he or she will allocate the points between WRPCs.	57%
6.d	When the individual identifies cultural preferences, the team updates the case formulation and may incorporate them into the individual's WRP objectives and interventions, as relevant.	57%

The facility's data showed positive change during this review period for sub-indicators 6.c and 6.d.

		Compliance: Partial. **Current recommendations**: 1. Continue current training and mentoring regarding engagement of individuals. 2. Monitor this requirement using process observation based on at least a 20% sample. 3. Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period)
C.2.b	Therapeutic and rehabilitation service planning provides timely attention to the needs of each individual, in particular:	Please see sub-cells for compliance findings.
C.2.b.i	initial therapeutic and rehabilitation service plans (Admission-Wellness and Recovery Plan ("A-WRP") are completed within 24 hours of admission;	**Current findings on previous recommendations:** **Recommendations 1 and 2, October 2007:** • Continue implementation of the A-WRP within 24 hours of the admission. • Continue monitoring to ensure that A-WRPs are completed within 24 hours of all admissions. **Findings:** ASH did not present data for this review period. The facility recognized errors in the implementation of self-monitoring and instituted corrective oversight actions effective March 2008. **Other findings:** This monitor reviewed the charts of six individuals admitted to Program IV (ALC, EW, LH, RLW, TH and THT) and four individuals admitted to other Programs (DRD, PH, PRI and VL). The review found

		compliance in all charts except one (THT). **Compliance:** Partial. **Current recommendations:** 1. Monitor this requirement using chart audits based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 3. Implement corrective actions to improve compliance.
C.2.b.ii	master therapeutic and rehabilitation service plans ("Wellness and Recovery Plan" (WRP)) are completed within 7 days of admission; and	**Current findings on previous recommendations:** **Recommendations 1 and 2, October 2007:** • Continue implementation of the master WRP within seven days of the admission. • Continue monitoring to ensure that 7-day WRPs are completed within seven days of all admissions, based on at least a 20% sample. **Findings:** Same as in C.2.b.i. **Other findings:** Reviewing the charts of the above-mentioned 10 individuals, this monitor found compliance in all charts except two (PH and THT). **Compliance:** Partial. **Current recommendations:** 1. Monitor this requirement using chart audits based on at least a

		20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 3. Implement corrective actions to improve compliance.
C.2.b.iii	therapeutic and rehabilitation service plan reviews are performed every 14 days during the first 60 days of hospitalization and every 30 days thereafter. The third monthly review is a quarterly review and the 12th monthly review is the annual review.	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Implement the required WRPC schedule on all teams. **Findings:** ASH reported that it has implemented the required schedule on Programs IV and V, and plans to implement the schedule facility-wide by August 15, 2008. **Recommendation 2, October 2007:** Continue to monitor the implementation of the required WRPC schedule on all teams, based on at least a 20% sample. **Findings:** Same as in C.2.b.i. **Other findings:** Reviewing the charts of the above-mentioned 10 individuals, this monitor found compliance in six (ALC, DRD, EW, LH, PRI and TH) and noncompliance in (PH, RLW, THT and VL). **Compliance:** Partial. **Current recommendations:** 1. Implement the required WRPC schedule on all teams.

		2. Monitor this requirement using chart audits based on at least a 20% sample. 3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 4. Implement corrective actions to improve compliance.
C.2.c	Treatment rehabilitation and enrichment services are goal-directed, individualized, and informed by a thorough knowledge of the individual's psychiatric, medical, and psychosocial history and previous response to such services;	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Continue and strengthen training of WRPTs and include specific modules to ensure that: a. The case formulation: i. Includes appropriate review and analysis of assessments to identify the individual's needs in the psychiatric, medical and psychosocial domains; and ii. Adequately addresses the requirements in C.2. d; and b. Foci of hospitalization and objectives and interventions: i. Adequately address all identified needs of the individual in the above domains; and ii. Adequately address the requirements in C.2.e and C.2.f.i through C.2.f.vi. **Findings:** During this review period, ASH began training using the MSH modules regarding Case Formulation, Foci and Objectives, and Interventions and Mall Integration. The facility added clinical examples that address ASH specific legal commitments to these modules. ASH also developed a Case Formulation Practice Worksheet, which is currently being piloted. **Recommendation 2, October 2007:** Monitor this requirement and provide data regarding the care of

individuals with cognitive disorders, seizure disorders and/or substance abuse disorders

Findings:
ASH used the DMH Clinical Chart Auditing Form to assess compliance (November 2007 to February 2008). The average sample was 80% of monthly, quarterly and annual WRPs due on Program IV. The following is an outline of the sub-indicators and corresponding mean compliance rates:

2.a	*When a cognitive disorder is identified on Axis I, it is written in Focus I, and has at least one objective with an appropriately linked intervention.*	0%
2.b	*When substance abuse is identified on Axis I, it is written in Focus 5, and has at least one objective with an appropriately linked intervention.*	16%
2.c	*When mental retardation is identified on Axis II, all interventions are aligned with the cognitive functioning level of the individual.*	0%
2.d	*When seizure disorder is identified on Axis III, it is written in Focus 6, and has at least one objective with an appropriately linked intervention.*	33%

The facility recognized lack of compliance regarding cognitive impairments and has initiated corrective actions to enhance the WRP training curriculum in this area.

Other findings:
This monitor reviewed the charts of eight individuals diagnosed with a variety of cognitive disorders (GP, JT, MAC, MJG, SR, TG, TWS and WT) and five individuals diagnosed with seizure disorders (JLP, JT, KAT, MEW and TAQ).

		This review found some improvement in the documentation of objectives for individuals suffering from seizure disorders (JT, KAT, MEW and TAQ) and one individual diagnosed with Dementia Due to General Medical Condition and Alcohol-Induced Persisting Dementia (CC). The review also found some general improvement in the documentation of interventions designed to teach individuals suffering from seizure disorders about their conditions, treatments and side effects of treatment. Despite these areas of improvement, this monitor found persisting patterns of deficiencies that must be corrected to achieve substantial compliance in this area. The following is an outline of these deficiencies: 1. Individuals diagnosed with cognitive impairments: a. The WRPs did not include foci, objectives or interventions to address diagnoses of Dementia NOS (SR), Mild Mental Retardation (MAC, TWS and WT) and Dementia Due to General Medical Condition without Behavioral Disturbance (TG). b. The WRP did not include objectives or interventions to address a diagnosis of Alcohol-Induced Persisting Dementia (JT). c. The present status section of the case formulation did not document the cognitive status of an individual diagnosed with Dementia Due to General Medical Condition without Behavioral Disturbances (TG). d. There is a discrepancy between the psychiatric documentation and the corresponding WRP regarding the presence or absence of a diagnosis of Dementia Due to General Medical Condition without Behavioral Disturbances (TG). e. The psychiatric documentation did not address high-risk medication uses for individuals diagnosed with Mild Mental Retardation (TWS and WT), and Dementia NOS (SR). f. The WRP included inappropriate objectives and interventions to address diagnoses of Cognitive Disorder, NOS (MJG) and Dementia Due to General Medical Condition without Behavioral

		Disturbances (GP). g. The WRPs did not include current and adequate measures/consultations to assess, determine the etiology of and/or finalize diagnoses of Cognitive Disorder, NOS (MJG) and Dementia, NOS (SR). 2. Individuals diagnosed with seizure disorders: a. The WRPs did not include specific morphological diagnosis regarding the type of seizure disorder in any of the charts reviewed. b. The WRPs included objectives that were not meaningful or attainable for the individuals, focusing on continuing to take medications (JLP) or not having frequent seizure activity (KAT). c. The WRP included interventions that did not specify what staff will do to assist the individual in achieving the objective of identifying factors that would decrease incidents of seizures (TAQ). d. The present status sections of the WRPs did not address the status of the individual's seizure activity during the previous interval (JT). e. The WRPs did not include interventions to assess the risks of treatment with older anticonvulsant medications and to minimize their impact on the individual's behavior and cognitive status. Examples include individuals receiving phenytoin (JP, JT, KAT and MEW) and primidone (TAQ). Some of these individuals also suffered from documented cognitive impairments (for example, Alcohol-Induced Persisting Dementia [JT]), which increases the risk of these treatments. **Compliance:** Partial.

		Current recommendations: 1. Monitor this requirement using the Clinical Chart Auditing Form based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 3. Implement corrective actions to address the deficiencies outlined by this monitor above.
C.2.d	Therapeutic and rehabilitation service planning is based on a comprehensive case formulation for each individual that emanates from interdisciplinary assessments of the individual consistent with generally accepted professional standards of care. Specifically, the case formulation shall:	**Compliance:** Partial.
C.2.d.i	be derived from analyses of the information gathered from interdisciplinary assessments, including diagnosis and differential diagnosis;	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Increase case formulation training and ensure that the training includes clinical case examples, ongoing feedback and mentoring by WRP trainers/senior clinicians. **Findings:** Same as in C.1.a (Recommendation 2) and C.2.c (Recommendation 1). **Recommendation 2, October 2007:** Continue to monitor this requirement using the Clinical Chart Auditing Form and analyze and correct factors related to low compliance. **Findings:** Using the DMH Clinical Chart Auditing Form, ASH reported 0%

		compliance with this requirement. The mean compliance rates for requirements in C.2.d.ii to C.2.d.vi are listed for each corresponding cell below. The sub-indicators are listed to show the variability in compliance with components of each requirement, as necessary. **Other findings:** Chart reviews and WRPCs attended by this monitor demonstrated that ASH has made some progress as follows: 1. A draft of the case formulation was prepared prior to the meeting and the WRPTs reviewed the draft during the meeting. 2. Some WRPTs utilized the ASH Case Formulation Practice Worksheet during the WRPCs. 3. The case formulations were completed in the 6-p format. 4. The content of the present status section of the formulation was, in general, more comprehensive compared to the last review. 5. In general, the pertinent history and precipitating factors included more needed information compared to the last review. 6. In general, substance abuse was addressed as a precipitating and a perpetuating factor. However, the content of most of the formulations showed that the facility has to make further progress regarding the following: 1. The present status sections did not include sufficient review and analysis of important clinical events that require modifications in WRP interventions. The most significant deficiencies involved needed information in the reviews of: a. Use of restrictive interventions; b. Clinical progress regarding a variety of disorders and high-risk behaviors; and c. Clinical progress toward individualized discharge criteria. 2. There was inadequate linkage within different components of the

<table>
<tr><td></td><td></td><td>formulations and between the material in the case formulations and other key components of the WRP (e.g. foci of hospitalization, life goals, strengths, objectives and interventions).

These deficiencies must be corrected in order to achieve substantial compliance with this requirement.

Current recommendations:
1. Continue training on the Case Formulation Module to all WRPTs and ensure that the training utilizes clinical case examples and addresses the deficiencies outlined by this monitor above.
2. Monitor this requirement using the Clinical Chart Auditing Form based on at least a 20% sample.
3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).</td></tr>
<tr><td>C.2.d.ii</td><td>include a review of: pertinent history; predisposing, precipitating and perpetuating factors; previous treatment history, and present status;</td><td><table>
<tr><td>4.a</td><td>Pertinent history</td><td>19%</td></tr>
<tr><td>4.b</td><td>Predisposing factors</td><td>23%</td></tr>
<tr><td>4.c</td><td>Precipitating factors</td><td>7%</td></tr>
<tr><td>4.d</td><td>Perpetuating factors</td><td>5%</td></tr>
<tr><td>4.e</td><td>Previous treatment</td><td>0%</td></tr>
<tr><td>4.f</td><td>Present status</td><td>2%</td></tr>
</table></td></tr>
<tr><td>C.2.d.iii</td><td>consider biomedical, psychosocial, and psychoeducational factors, as clinically appropriate, for each category in § [III.B.4.b] above;</td><td><table>
<tr><td>5.a</td><td>There is a completed DMH WRP Case Formulation Worksheet</td><td>15%</td></tr>
<tr><td>5.b</td><td>The information is included in the case formulation</td><td>8%</td></tr>
</table></td></tr>
<tr><td>C.2.d.iv</td><td>consider such factors as age, gender, culture,</td><td></td></tr>
</table>

	treatment adherence, and medication issues that may affect the outcomes of treatment and rehabilitation interventions;	6.a	*All five factors: age, gender, culture, treatment adherence, and medication issues (are included)*	37%
		6.b	*(The formulation) addresses how they affect treatment and rehabilitation outcomes*	2%
C.2.d.v	support the diagnosis by diagnostic formulation, differential diagnosis and Diagnostics and Statistical Manual DSM-IV-TR (or the most current edition) checklists; and	7.a	*There is a completed DSM IV-TR Checklist that was completed prior to the 7-day WRP, and thereafter*	10%
		7.b	*There is a completed DSM IV-TR Checklist that was completed when there is a change of a psychiatric diagnosis*	10%
C.2.d.vi	enable the interdisciplinary team to reach sound determinations about each individual's treatment, rehabilitation, enrichment and wellness needs, the type of setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge.	8.a	*The present status section addresses Rehabilitation and Enrichment*	2%
		8.b	*The case formulation identifies required changes in individual and systems to optimize treatment, rehabilitation and enrichment outcomes*	7%
		8.c	*The case formulation documents a pathway to the discharge setting*	13%
		8.d	*There is evidence of proper analysis of the following information: of identification of foci, objectives treatment, rehabilitation, and enrichment interventions and there is linkage between the case formulation and the foci of hospitalization, life goals and objectives and interventions.*	3%
		8.e	*There is proper linkage within different sections of the case formulation when a factor in one section is related to a factor in another section*	3%
		8.f	*There is evidence of proper analysis of the following*	1%

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<tr><td></td><td>information: of identification of foci, objectives treatment, rehabilitation, and enrichment interventions and there is linkage between the case formulation and the foci of hospitalization, life goals and objectives and interventions.</td><td></td></tr>
<tr><td>8.g</td><td>The case formulation identifies reasonable and attainable goals/objectives (e.g., at the level of each individual's functioning) that build on the individual's strengths and address the individual's identified needs.</td><td>4%</td></tr>
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<tr>
<td>C.2.e</td>
<td>The therapeutic and rehabilitation service plan specifies the individual's focus of hospitalization (goals), assessed needs (objectives), and how the staff will assist the individual to achieve his or her goals/objectives (interventions);</td>
<td>Current findings on previous recommendation:

Recommendation, October 2007:
Same as in C.2.c, C.2.f, C.2.g and C.2.o.

Findings:
Same as in C.2.c, C.2.f, C.2.g and C.2.o.

Findings:
Same as in C.2.c, C.2.f, C.2.g and C.2.o.

Other findings:
Psychosocial Rehabilitation Therapists have revised the Integrated Assessment-Rehabilitation Therapy Section tool and instructions to include assessment recommendations in the form of focus, objectives, and interventions. Due to recent implementation, no facility data was available for the September 2007-February 2008 review period. Instructions for focused Rehabilitation Therapy assessments are currently in the process of being revised to reflect WRP language, including recommendations for focus, objectives, and interventions, and thus no data facility data was available for review.</td>
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		Record review of a sample of RIAT Pilot assessments from November 2007-December 2007 and IA-RTS assessments from January-February 2008 found that 58% of corresponding WRP documents contained Rehabilitation Therapy foci, 24% contained WRP inclusion of objectives and 47% contained WRP inclusion of interventions. Review of a sample of records of individuals with Physical, Speech, or Vocational Rehabilitation assessment/consultation during the August 2007-January 2008 review period found that 26% of corresponding WRP documents contained Occupational, Physical, and/or Speech Therapy foci, none contained WRP inclusion of objectives and 22% contained WRP inclusion of interventions. Record review of individuals participating in Rehabilitation Therapist-led PSR Mall groups found that 28% had WRP documentation of focus, 22% had WRP documentation of objectives and 28% had WRP documentation of interventions. Review of records of individuals receiving direct Occupational, Physical, and Speech Therapy showed that 40% had WRP documentation of focus, none had WRP documentation of objectives and 20% had WRP documentation of interventions. Review of a sample of Nutrition Care assessments completed across assessment sub-types found that 46% of corresponding WRP documents contained Nutrition Care recommendations, although these recommendations were not written in the form of foci, objectives and interventions. **Compliance:** Partial.

		Current recommendations: Same as in C.2.c, C.2.f, C.2.g and C.2.o.
C.2.f	Therapeutic and rehabilitation service planning is driven by individualized needs, is strengths-based (i.e., builds on an individual's current strengths), addresses the individual's motivation for engaging in wellness activities, and leads to improvement in the individual's mental health, health and well being, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:	Please see sub-cells for compliance findings.
C.2.f.i	develop and prioritize reasonable and attainable goals/objectives (e.g., at the level of each individual's functioning) that build on the individual's strengths and address the individual's identified needs and, if any identified needs are not addressed, provide a rationale for not addressing the need;	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Increase training sessions regarding objectives and interventions, and provide ongoing feedback and mentoring by senior clinicians. **Findings:** Same as in C.1.a (Recommendation 2) and C.2.c (Recommendation 1). **Recommendation 2, October 2007:** Continue to monitor this requirement and analyze and correct factors regarding low compliance. **Findings:** ASH used the DMH WRP Observation Monitoring Form to assess compliance (November 2007 to February 2008). The average sample was 63% of the 7-day, 14-day, monthly, quarterly and annual WRPCs due on Program IV. The mean compliance rate was 8%. The following is an outline of the sub-indicators and corresponding mean compliance rates:

		<table><tr><td>7.a</td><td>Strengths are identified and incorporated into the interventions offered</td><td>9%</td></tr><tr><td>7.b</td><td>The strengths are related to each treatment, rehabilitation or enrichment objective</td><td>8%</td></tr></table> As mentioned in section C.1, the facility recognized that the data collected from chart audits were unreliable due to a process error and reported a change in administrative oversight as a corrective action. **Other findings:** This monitor reviewed the charts of three individuals on Program IV (MJP, ODM and TH) and three individuals on other Programs (EVF, JE and RLW). The review found partial compliance in all cases. **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 3. Implement corrective actions to improve compliance.
C.2.f.ii	ensure that the objectives/ interventions address treatment (e.g., for a disease or disorder), rehabilitation (e.g., skills/supports, motivation and readiness), and enrichment (e.g., quality of life activities);	**Current findings on previous recommendation:** **Recommendation, October 2007:** Same as above. **Findings:** ASH did not provide chart audit data (see C.2.f.i).

		Other findings: Reviewing the charts of the six individuals noted in C.2.f.i, this monitor found compliance in all cases. **Compliance:** Partial. **Current recommendations**: Same as in C.2.f.i.
C.2.f.iii	write the objectives in behavioral, observable, and/or measurable terms;	**Current findings on previous recommendation:** **Recommendation, October 2007:** Same as above. **Findings:** Same as above. **Other findings:** This monitor found partial compliance in all charts reviewed (EVF, JE, MJP, ODM, RLW and TH). **Compliance:** Partial. **Current recommendations**: Same as in C.2.f.i.
C.2.f.iv	include all objectives from the individual's current stage of change or readiness for rehabilitation, to the maintenance stage for each focus of hospitalization, as clinically appropriate;	**Current findings on previous recommendation:** **Recommendation, October 2007:** Same as above.

		Findings: Same as above. **Other findings:** Reviews by this monitor found noncompliance in all charts (EVF, JE, MJP, ODM, RLW and TH). **Compliance:** Noncompliance. **Current recommendations**: Same as in C.2.f.i.
C.2.f.v	ensure that there are interventions that relate to each objective, specifying who will do what, within what time frame, to assist the individual to meet his/her needs as specified in the objective;	**Current findings on previous recommendation:** **Recommendation, October 2007:** Same as above. **Findings:** Same as above. **Other findings:** This monitor found compliance in two charts (ODM and RLW) and partial compliance in four (EVF, JE, MJP and TH). **Compliance:** Partial. **Current recommendations**: Same as in C.2.f.i.
C.2.f.vi	implement interventions appropriately throughout the individual's day, with a minimum of 20 hours of	**Current findings on previous recommendations:**

active treatment per week. Individual or group therapy included in the individual's WRP shall be provided as part of the 20 hours of active treatment per week;

Recommendation 1, October 2007:
Correct factors related to inadequate scheduling by the WRPTs, inaccurate reporting of hours scheduled on the WRP, discrepancies between WRP and MAPP data and inadequate participation by individuals.

Findings:
ASH reported the following corrective actions:

WRP training and mentoring process now address the deficiencies regarding scheduling of active treatment hours and discrepancies between WRP and MAPP data.
Recovery and Mall Services (RMS) recently developed and implemented (April 2008) a plan to correct the factors contributing to inadequate scheduling, data discrepancies and limited participation by individuals. The plan includes RMS coordination of the MAPP rosters, Mall Progress Notes and Add/Drop Requests (regarding Mall groups).

Recommendation 2, October 2007:
Monitor hours of active treatment (scheduled and attended).

Findings:
The following is a summary of the facility's data regarding the number of hours of active treatment attended as scheduled on Program IV during this review period:

2007/2008	Sep	Oct	Nov	Dec	Jan	Feb	Mean
N	192	208	208	202	204	195	202
n	192	208	208	202	204	195	202
%S	100	100	100	100	100	100	100
0-1 hr	17	29	27	30	25	19	25
1-5 hrs	60	73	86	74	83	88	77
6-10 hrs	35	46	52	58	47	49	48

11-15 hrs	52	54	52	43	39	39	47
16-19 hrs	20	12	14	20	19	10	16
20+ hrs	1	2	3	2	3	5	3

The facility did not provide data analysis. However, the data showed a significant increase in the number of individuals in the categories up to 15 hours and a decline in the category of 16-plus hours compared to the last review period.

ASH also presented facility-wide data, including Program IV. The following is a summary outline:

2007/2008	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mean**
N	1087	1152	1178	1156	1190	1213	1163
n	1087	1152	1178	1156	1190	1213	1163
%S	100	100	100	100	100	100	100
0-1 hr	261	283	266	267	263	267	268
1-5 hrs	549	552	590	595	593	648	588
6-10 hrs	131	164	167	155	187	171	163
11-15 hrs	75	91	78	70	69	64	75
16-19 hrs	32	28	22	28	32	23	28
20+ hrs	39	34	55	41	46	40	43

Other findings:
This monitor reviewed the six charts to assess documentation of active treatment hours listed on the most recent WRP and corresponding MAPP data regarding hours scheduled and attended:

	WRP scheduled	**MAPP scheduled**	**MAPP attended**
RLW	4	17	13
JE	1	2.4	0

		<table><tr><td>MJP</td><td>10</td><td>13.2</td><td>2</td></tr><tr><td>EVF</td><td>11</td><td>23.3</td><td>19.3</td></tr><tr><td>TH</td><td>11</td><td>1</td><td>1</td></tr><tr><td>ODM</td><td>17</td><td>19</td><td>15.2</td></tr></table> The monitor's reviews showed that the facility has yet to correct the significant discrepancy between WRP and MAPP data and to ensure scheduling and attendance by the individuals as required by this EP cell. **Compliance:** Partial. **Current recommendations:** Monitor hours of active treatment (scheduled and attended). Correct factors related to inadequate scheduling by the WRPTs, inaccurate reporting of hours scheduled on the WRP, discrepancies between WRP and MAPP data and inadequate participation by individuals.
C.2.f.vii	maximize, consistent with the individual's treatment needs and legal status, opportunities for treatment, programming, schooling, and other activities in the most appropriate integrated, non-institutional settings, as clinically appropriate; and	This requirement did not apply to ASH during this review period.
C.2.f.viii	ensure that each therapeutic and rehabilitation service plan integrates and coordinates all services, supports, and treatments provided by or through each State hospital for the individual in a manner specifically responsive to the plan's therapeutic and rehabilitation goals. This	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Ensure proper linkage between type and objective of Mall activities and objectives outlined in the WRP, as well as documentation of this linkage.

	requirement includes but is not limited to ensuring that individuals are assigned to mall groups that link directly to the objectives in the individual's WRP and needs.	**Findings:** ASH reported that the current WRP training process (see C.1.a) now addresses linkages between Mall activities and WRP objectives. The WRP Master Trainer and Mall Director reportedly meet on a regular basis to address this linkage. **Recommendation 2, October 2007:** Monitor this requirement and analyze and correct factors related to inconsistent/low compliance. **Findings:** ASH used the new DMH Mall Alignment Monitoring Form to assess compliance (October 2007 to February 2008) based on an average sample of 85% (N=20 charts). The facility reported a mean compliance rate of 55%. The data are limited by the fact that the facility has yet to establish inter-rater reliability for Mall alignment monitoring as well as the small sample size and instability in the composition of the auditor group. **Recommendation 3, October 2007:** Implement electronic progress note documentation by all Mall and individual therapy providers and ensure integration of data, as needed, into the WRPs. **Findings:** ASH reported that the electronic progress note is still under development as part of the WaRMSS system. In September 2007, the facility began implementation of the Quarterly Mall Progress Note documentation in all programs. As mentioned earlier, the RMS has developed a system to facilitate processing of these progress notes. **Other findings:** Chart reviews by this monitor found partial compliance in four (EVF,

		MJP, ODM and RLW), compliance in one (TH) and noncompliance in one (JE). **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using the Mall Alignment Monitoring Form. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 3. Implement electronic progress note documentation by all Mall and individual therapy providers and ensure integration of data, as needed, into the WRPs. 4. Improve compliance with the completion of Mall progress notes and the integration of information into the WRPs.
C.2.g	Therapeutic and rehabilitation service plans are revised as appropriate to ensure that planning is based on the individual's progress, or lack thereof, as determined by the scheduled monitoring of identified criteria or target variables, consistent with generally accepted professional standards of care. Specifically, the interdisciplinary team shall:	Please see sub-cells for compliance findings.
C.2.g.i	revise the focus of hospitalization, objectives, as needed, to reflect the individual's changing needs and develop new interventions to facilitate attainment of new objectives when old objectives are achieved or when the individual fails to make progress toward achieving these objectives;	**Current findings on previous recommendation:** **Recommendation, October 2007:** Monitor this requirement using both process observation and clinical chart auditing, and analyze and correct factors related to low compliance.

Findings:
ASH used the DMH WRP Observation Monitoring Form to assess compliance (November 2007 to February 2008). The mean compliance rate was 7%. The following outlines the sub-indicators and corresponding mean compliance rates:

8.a	*When an objective has been achieved the team develops a new objective and associated intervention(s) for that focus of hospitalization.*	10%
8.b	*When an individual has not shown progress on an objective for two months the team revises or develops a new objective or a new intervention.*	6%

Using the DMH Clinical Chart Auditing Form (November 2007 to February 2008), the facility reported a mean compliance rate of 3%. A breakdown of the data showed compliance rates of 6% and 3% with the above sub-indicators, respectively.

Other findings:
This monitor found noncompliance in four charts (EVF, JE, MJP and ODM) and compliance in two (RLW and TH).

Additionally, according to record review, 13% of records of individuals participating in Rehabilitation Therapist-led PSR Mall groups included WRP documentation of revision of focus, objectives, and/or interventions according to individualized needs. Eighty-seven percent of records of individuals receiving direct Physical and/or Speech Therapy contained evidence that treatment modalities and interventions were modified as needed in response to individuals' needs, though none of these records contained WRP documentation of revision of focus, objectives, and/or interventions according to individualized needs

		Compliance: Partial. **Current recommendations**: 1. Monitor this requirement using both process observation and chart auditing, based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 3. Implement corrective actions to ensure consistent implementation of the Mall progress notes and the integration of available notes to ensure timely and appropriate revisions of the WRP.
C.2.g.ii	review the focus of hospitalization, needs, objectives, and interventions more frequently if there are changes in the individual's functional status or risk factors (i.e., behavioral, medical, and/or psychiatric risk factors);	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Implement corrective actions to ensure: a) Review by the WRPTs of the circumstances related to the use of restrictive interventions; and b) Timely and appropriate modification of the WRPs in response to the review. **Findings:** ASH has yet to implement this recommendation. The facility has a plan to facilitate implementation effective April 2008. This plan includes use of the following two forms: 1. RN Significant Change in Condition Assessment Note; and 2. RN Assessment for the Authorization of Restraint or Seclusion. **Recommendation 2, October 2007:** Continue to monitor this requirement using observation and chart auditing and analyze and correct factors related to low compliance.

Findings:
ASH used the DMH WRP Observation Monitoring Form (November 2007 to February 2008) and reported a mean compliance rate of 38%. Using the DMH Chart Auditing Form (November 2007 to February 2008), the facility reported mean compliance of 3%. The facility did not provide analysis to address the discrepancy between the process of team review and documentation of this review.

Recommendation 3, October 2007:
Revise current monitoring tool to include individuals whose functional status has improved.

Findings:
The DMH has implemented this recommendation. The WRP Process Observation Monitoring Form contains an indicator that addresses this condition.

Other findings:
This monitor reviewed the charts of five individuals who had experienced the use of seclusion and/or restraints during this reporting period (AE, CG-2, JCB, JLF and MJC). The following table outlines this review:

Individual	Date of seclusion and/or restraint	Date of applicable WRP review
JCB	01/19/08	03/06/08
MJC	12/25/07	02/07/08
AE	11/17/07	01/29/08
JLF	1/28/08	03/11/08
CG-2	01/07/08	01/09/08

The review found that only two charts contained documentation of the

		events that led to the use (AE and CG-2) and only one chart (CG-2) contained documentation of modification of treatment based on the use of these interventions. **Compliance:** Partial. **Current recommendations**: 1. Implement corrective actions to ensure: a. Review by the WRPTs of the circumstances related to the use of restrictive interventions; and b. Timely and appropriate modification of the WRPs in response to the review. 2. Monitor this requirement using both process observation and chart auditing, based on at least a 20% sample. 3. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period). 4. Implement corrective actions to ensure consistent implementation of the Mall Progress Notes and the integration of available notes to ensure timely and appropriate revisions of the WRP.
C.2.g.iii	ensure that the review process includes an assessment of progress related to discharge to the most integrated setting appropriate to meet the individuals assessed needs, consistent with his/her legal status; and	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Ensure that WRP training includes a specific module regarding discharge planning in accordance with requirements of the EP and the DMH WRP manual. **Findings:** During this review period, ASH began training using the MSH module on discharge planning. The facility added clinical examples relevant to ASH-specific legal commitments.

Recommendation 2, October 2007:
Monitor this requirement and analyze and correct factors related to low compliance.

Findings:
Using the DMH WRP Process Observation Monitoring Form (November 2007 to February 2008), ASH reported a mean compliance rate of 10%. A breakdown of the data showed variable compliance with the sub-indicators as follows:

10.a	*The team reviews all Foci that are barriers to discharge.*	31%
10.b	*The team reviews the PSR Mall Facilitator's Monthly Progress Notes for all objectives related to discharge.*	6%

Other findings:
This monitor reviewed the charts of six individuals. The charts included either partial (JE, MJP, ODM, RLW and TH) or no delineation (EVF) of individualized discharge criteria. Only two charts (EVF and TH) included adequate documentation in the present status section of the team's discussion of progress towards discharge.

Compliance:
Partial.

Current recommendations:
1. Monitor this requirement using both process observation and chart auditing, based on at least a 20% sample.
2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period and compared to the last period).

<table>
<tr><td></td><td></td><td>3. Develop and implement corrective actions to ensure that discharge criteria are individualized and that the WRPTs document their discussion of progress towards discharge criteria.</td></tr>
<tr><td>C.2.g.iv</td><td>base progress reviews and revision recommendations on data collected as specified in the therapeutic and rehabilitation service plan.</td><td>Current findings on previous recommendation:

Recommendation, October 2007:
Monitor this requirement using process observation and analyze and correct factors related to low compliance.

Findings:
ASH used the DMH WRP Process Observation Monitoring Form (November 2007 to February 2008). The facility reported a mean compliance rate of 3%. A breakdown of the data showed variable compliance with the sub-indicators as follows:

<table>
<tr><td>11.a</td><td>The team reviews the PSR Mall Facilitator's Monthly Progress Notes for all current objectives and interventions for this individual.</td><td>5%</td></tr>
<tr><td>11.b</td><td>Revisions to the WRP are based on the data provided by the group facilitator or individual therapist in the PSR Mall Facilitator's Monthly Progress Notes, if applicable.</td><td>8%</td></tr>
</table>

Other findings:
This monitor's review of six charts found that Mall progress notes were completed in five charts (EVF, JE, MJP, ODM and RLW). However, none of the charts included evidence that the information in the progress notes was adequately incorporated in the WRP reviews (the chart of RLW included some integration of this information).

Compliance:
Partial.</td></tr>
</table>

		Current recommendations: 1. Same as in C.2.g.i. 2. Same as in C.2.f.viii.
C.2.h	Individuals in need of positive behavior supports in school or other settings receive such supports consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation 1, October 2007:** Increase the number of PBS teams as specified in the Enhancement Plan. **Findings:** ASH is short of a full PBS team to meet the 1:300 ratio. ASH is actively recruiting to fill the vacant positions. **Recommendation 2, October 2007:** Ensure that all staff implement PBS plans and collect reliable and valid outcome data. **Findings:** ASH did not develop or implement any PBS plans during the last six months. **Recommendation 3, October 2007:** Provide competency-based training to all staff in PBS procedures, and provide ongoing training and support for PBS team members as needed. **Findings:** ASH did not develop or implement any PBS plans during the last six months. **Recommendation 4, October 2007:** Develop behavioral guidelines for any individual who has severe

		maladaptive behaviors, as stated in the DMH WRP Manual. **Findings:** ASH has significantly increased the number of behavioral guidelines. However, the number of individuals exhibiting maladaptive behaviors without any behavioral interventions remains high as evidenced by the diagnosis and open foci and the number of individuals experiencing restraints, seclusion, isolation, and PRN and Stat medications. **Recommendation 5, October 2007:** Ensure that WRPT members understand when they should refer individuals to the PBS team. **Findings:** This monitor's documentation review and interview with the Chief of Psychology found that WRPT members were provided training on aspects of making appropriate referrals to the PBS teams. Staff also has had the opportunity to attend the monthly training offered during the "New Employee Orientation." This monitor also interviewed WRPT members, all of whom were familiar with the process of referring individuals to the PBS teams. **Compliance:** Partial. **Current recommendations:** 1. Increase the number of PBS teams as specified in the Enhancement Plan. 2. Ensure that all staff implement PBS plans and collect reliable and valid outcome data. 3. Provide competency-based training to all staff in PBS procedures, and provide ongoing training and support for PBS team members as needed.

		4. Develop behavioral guidelines for any individual who has severe maladaptive behaviors, 5. Ensure that WRPT members understand when they should refer individuals to the PBS team.
C.2.i	Adequate active psychosocial rehabilitation is provided, consistent with generally accepted professional standards of care, that:	**Compliance:** Partial.
C.2.i.i	is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions;	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Ensure that discipline-specific assessments include a section that states the implications of the assessment for rehabilitation activities. **Findings:** The following discipline-specific assessments include a section that states the implications of the assessment for rehabilitation activities: Integrated Assessment: Psychology Section (Section 7), Integrated Social work Assessment (Section 15), and the Integrated Rehabilitation Assessment (Section 6). **Recommendation 2, October 2007:** The WRPT should integrate relevant information from discipline-specific assessments and prioritize the individual's assessed needs. **Findings:** This monitor reviewed seven charts (BF, DAD, DSA, EI, JWB, RE and TC). Four of the WRPs in the charts (DAD, EI, RE and TC) had integrated the relevant information from the discipline-specific assessments into the individuals' WRPs. The remaining three (BF, DSA and JWB) did not include the relevant information from the discipline-specific assessments in the individuals' WRPs.

		Recommendation 3, October 2007: Ensure that group leaders are consistent and enduring for specific groups. **Findings:** This monitor's documentation review and interview of Matt Hennessy (Mall Director) found that Program Management and Providers are to attend Program Management Meetings on a daily basis to ensure that groups are covered and that providers are consistently attending groups as scheduled. This monitor's documentation review (Delinquent Attendance Roster, Weekly MAPP Report) showed that the providers were consistent in the groups on a week-to-week basis. However, it is not possible to tell from the documentation if the providers actually facilitated the groups. This monitor observed several Mall groups (Depression and Crisis Management, Symptom Management, and Coping with Anxiety). Interviews with individuals attending these groups and interviews of the providers found that the providers facilitating these groups were consistent. In one case (MM), the WRP (April 2008) had identified a staff member who was no longer at the facility. **Recommendation 4, October 2007:** Provide Motivational Interviewing, Narrative Restructuring Therapy and other cognitive behavioral interventions to individuals who refuse to attend groups as specified in their WRPs. **Findings:** This monitor's review of ASH's Delinquent Attendance Rosters found that on average, individuals attend about half of the groups they are scheduled to attend.

This monitor's documentation review found that staff in ASH is receiving training on Motivational Interviewing and Narrative Restructuring Therapy from Drs. Judy Singh and Robert Wahler (September 2007 and February 2008). However, three of the six staff who received training have left the program. The remaining three are working with individuals who refuse to attend groups.

ASH has taken a number of steps to minimize non-participation, including convening Pre-Mall meetings to encourage individuals to attend their scheduled groups, and organizing a special group called the "Ready, Set, Go" for individuals who refuse to attend groups including those who are not psychiatrically stable to be out of their units and to participate in some type of activity.

The table below showing the number of individuals in Program IV (N), and the number of individuals who were non-adherent to 80% of their WRP (n) is a summary of the facility's data.

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
N	180	208	208	202	204	195	204
n	175	116	122	165	167	182	155

The table below showing the census for each month (N) and the number of individuals who were non-adherent to 80% of their WRP (n) is a summary of the facility's data.

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
N	975	1096	1120	1133	1186	1202	1119
n	958	815	858	1019	1043	1065	960

According to the Mall Director, the data on non-adherence to Mall groups may not be accurate because individuals are listed as non-adherent when the group rosters are not completed and submitted in a

timely manner.

The Mall Director and the Clinical Administrator indicated that ASH does not have the staff to handle the large number of individuals who fail to attend groups on a regular basis.

Recommendation 5, October 2007:
Track and monitor this objective.

Findings:
ASH used item #2 from the DMH Mall Alignment Monitoring Form (*Is based on the individual's assessed needs and is directed toward increasing the individual's ability to engage in more independent life functions*) to address this objective, reporting 75% compliance. The table below with its monitoring indicator showing the number of charts designated for auditing (N), the number of charts actually audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
N	20	20	20	20	20	20	
n	18	17	15	17	17	19	
%S	90	85	75	85	85	95	
%C # 2	72	53	73	94	82	74	75

This monitor reviewed 11 charts (ADG, AH, AS, CC, DSA, EI, JL, LT, LW, SRB and TLC). Documentation in five of the WRPs in the charts (AH, AS, CC, JL and LT) had prioritized the individual's needs through appropriate focus of hospitalization, discharge criteria, and stage of change, thereby increasing the individual's opportunity for independent life functions and progress towards discharge. The remaining six (ADG, DSA, EI, LW, SRB and TLC) had one or more elements missing or incorrectly applied. For example, SRB's WRP did not address all

		relevant foci, and all foci did not have appropriate groups for the individual to learn/practice skills to increase independence. Additionally TLC"s assessed needs were not met; LW's case formulation was not comprehensive, the focus and objective did not match, and an intervention was incomplete. **Other findings:** Record review of individuals participating in Rehabilitation Therapist-led PSR Mall groups found that 44% of PSR Mall group objectives and interventions were aligned with assessment findings regarding individual needs and strengths. Record review of individuals receiving direct Physical and/or Speech Therapy found that 94% of treatment activities were aligned with assessment findings of individual needs. **Current recommendations:** 1. The WRPT should integrate relevant information from discipline-specific assessments and prioritize the individual's assessed needs. 2. Ensure that group leaders are consistent and enduring for specific groups. 3. Provide Motivational Interviewing, Narrative Restructuring Therapy and other cognitive behavioral interventions to individuals who refuse to attend groups as specified in their WRPs. 4. Track and monitor this objective.
C.2.i.ii	Has documented objectives, measurable outcomes, and standardized methodology	**Current findings on previous recommendations:** **Recommendation 1 and 2, October 2007:** • Ensure that the objectives are written in behavioral, observable and/or measurable terms, as specified in the DMH WRP Manual. • Ensure that the learning outcomes are stated in measurable terms.

Findings:
This monitor's documentation review (WRP training manual, course outline) and interview of staff found that treatment team members, including nursing and psychiatric technicians, attended three hours of training on Wellness and Recovery Planning.

ASH used item #3 from the DMH Mall Alignment Monitoring Form (*Has documented objectives, measurable outcomes, and standardized methodology*) to address this recommendation, reporting 40% compliance. The table below with its monitoring indicator showing the number of charts designated for auditing (N), the number of charts actually audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
N	20	20	20	20	20	20	
n	18	17	15	17	17	19	
%S	90	85	75	85	85	95	
%C #3	44	35	33	53	53	21	40

This monitor reviewed seven charts (BF, DD, DSA, EI, JWB, TC and TLC). Five of the WRPs in the charts (BF, EI, JWB, TC and TLC) had the objectives written in a measurable/observable manner, and the remaining two (DD and DSA) did not have one or more of the objectives written in a measurable/observable manner.

Recommendation 3, October 2007:
Ensure that each objective is directly linked to a relevant focus of hospitalization.

Findings:
This monitor reviewed 11 charts (AE, AS, BF, DD, DSA, EI, JW, JWB, MSB, RC and TLC). The objectives in nine of the WRPs in the charts

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<td>(AE, AS, BF, DD, DSA, EI, JWB, MSB and RC) were directly linked to a relevant focus of hospitalization and two of them were not (JW and TLC).

Current recommendations:
1. Ensure that the objectives are written in behavioral, observable and/or measurable terms, as specified in the DMH WRP Manual.
2. Ensure that the learning outcomes are stated in measurable terms.
3. Ensure that each objective is directly linked to a relevant focus of hospitalization.</td>
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<tr>
<td>C.2.i.iii</td>
<td>Is aligned with the individual's objectives that are identified in the individual's Wellness and Recovery Plan</td>
<td>Current findings on previous recommendations:

Recommendation 1, October 2007:
Ensure that all therapies and rehabilitation services provided in the malls are aligned with the assessed needs of the individuals.

Findings:
ASH used item #4 from the DMH Mall Alignment Monitoring Form (Is aligned with the individual's objectives that are identified in the individual's wellness and recovery plan) to address this recommendation, reporting 41% compliance. The table below with its monitoring indicator showing the number of charts designated for auditing (N), the number of charts actually audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

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<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean</td></tr>
<tr><td>N</td><td>20</td><td>20</td><td>20</td><td>20</td><td>20</td><td>20</td><td></td></tr>
<tr><td>n</td><td>18</td><td>17</td><td>15</td><td>17</td><td>17</td><td>19</td><td></td></tr>
<tr><td>%S</td><td>90</td><td>85</td><td>75</td><td>90</td><td>85</td><td>95</td><td></td></tr>
<tr><td>%C #4</td><td>44</td><td>24</td><td>47</td><td>53</td><td>47</td><td>32</td><td>41</td></tr>
</table>

This monitor reviewed six charts (BF, DD, DSA, EI, JWB and TLC).</td>
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		The services provided for three individuals in their WRPs (BF, DD and JWB) were aligned with the individuals' assessed needs; the remaining three (DSA, EI and TLC) did not meet the criteria. **Recommendation 2, October 2007:** When assigning individuals to Mall groups, the WRPT members should be familiar with the contents of the groups they recommend so that the groups are aligned with the individual's needs. **Findings:** This monitor's documentation review (Mall catalog, Mall course outline) and observation of WRPT conferences (CM and MG) found that the WRPTs had the Mall catalogue with them and referred to it when discussing individuals' group assignments. The Mall director indicated that he continually updates new course descriptions for WRPT use. **Recommendation 3, October 2007:** Group leaders should be held accountable for following the Mall curricula. **Findings:** This monitor's interview of the Mall Director and the Clinical Administrator revealed that ASH plans to hire additional senior clinicians to address this recommendation. ASH is using direct observation to give feedback to facilitators, and audits are conducted using the Mall Facilitator Audit Form. This monitor used items from the Mall Consultation Checklist to evaluate the providers in the Mall groups observed by this monitor (Depression and Crisis Management; Symptom Management; Coping with Anxiety). The data obtained is as follows: • Lesson Plan is available and followed – 100%.

		• Facilitator is familiar with lesson plan/materials – 100%. • Facilitator engages each person in the session – 100%. • Facilitator keeps participants "on task" – 66%. • Facilitator presentation is engaging/effective -100%. • Facilitator tests participants understanding - 66%. • Presentation is clear and orderly – 100%. • Presentation is geared to the comprehensive level – 33%. **Recommendation 4, October 2007:** Ensure that the Mall director has the necessary staff to assist with Mall programming and management. **Findings:** This monitor's interview of the Mall Director found that ASH has increased the staffing positions allocated for Rehabilitation and Mall Services (RMS) section. Positions allocated for RMS include a Mall Director, Assistant Mall Director, Mall Coordinators (7), Assistant Mall Coordinators (7, Mall central campus staff (5), and Office Technicians-MAPP data entry and coordination (4). ASH is actively recruiting to fill some of the vacant positions. **Current recommendations**: 1. Ensure that all therapies and rehabilitation services provided in the Malls are aligned with the assessed needs of the individuals. 2. Group leaders should be held accountable for following the Mall curricula. 3. Ensure that the Mall director has the necessary staff to assist with Mall programming and management.
C.2.i.iv	utilizes the individual's strengths, preferences, and interests;	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Ensure that the individual's strengths, preferences, and interests are

		clearly specified in the interventions in the individual's WRP in accordance with the DMH WRP manual. **Findings:** This monitor's documentation review (training documentation/ attendance roster, course content) found that ASH has conducted WRP training for the unit staff including all Program IV and V Treatment Team Members, Program Management Staff, mentors, and auditors. According to the Mall Director, the WRP Master Trainer and Mentors provide ongoing training and support to WRPT members. This monitor reviewed eight charts (BF, DAD, DSA, EI, JWB, MG, RE and TC). All eight WRPs in the charts had strengths identified for the interventions. However, the quality of the strengths identified in those interventions was poor. In most cases, the strengths were restricted to the individual's "desire," for example "desire to be symptom-free" (DSA), "desire to learn while he was here" (BF), or "use his interest in leaving this place" (MG). These identified strengths cannot be directly utilized by the facilitators to motivate the individual to participate in the group, organize/structure the group, prepare specific handouts, accelerate learning, or modify the instructional sets. WRPTs should consider including the individual's interests and preferences in place of or in addition to, the individual's strengths. **Recommendation 2, October 2007:** Ensure that the group facilitators and individual therapists know and use the individual's strengths, preferences and interests when delivering rehabilitation services. **Findings:** This monitor's documentation review (Monthly Progress Note Pathway, training documentation/sign-in sheets) and interview of the Mall Director revealed that group facilitator training (April 8, 2008)

included information on accessing individuals' strengths, preferences and interests in their groups through the Mall Progress Notes. According to the Mall Director, Senior Clinicians were assigned to Program IV to monitor facilitators. The Mall director intends to do the same for all Mall groups when additional Senior Clinicians are made available for auditing.

ASH used item #5 from the DMH Mall Alignment Monitoring Form (*Utilizes the individual's strengths, preferences and interests*) to address this recommendation, reporting 31% compliance. The table below with its monitoring indicator showing the number of charts designated for auditing (N), the number of charts actually audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
N	20	20	20	20	20	20	
n	18	17	15	17	17	19	
%S	90	85	75	85	85	95	
%C #5	22	29	47	35	29	26	31

This monitor's interview with the group facilitators (Depression and Crisis Management, Symptom Management, and Coping with Anxiety), and observation of the groups found that the providers were familiar with the strengths of a few but not all of the individuals in their groups.

Current recommendations:

1. Ensure that the individual's strengths, preferences, and interests are clearly specified in the interventions in the individual's WRP in accordance with the DMH WRP manual.
2. Ensure that the group facilitators and individual therapists know and use the individual's strengths, preferences and interests when

<table>
<tr><td></td><td></td><td>delivering rehabilitation services.</td></tr>
<tr><td>C.2.i.v</td><td>focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate;</td><td>Current findings on previous recommendations:

Recommendation 1, October 2007:
Undertake clinical case formulation as a team rather than by assigning the task to a team member or to non-team members.

Findings:
This monitor reviewed eight charts (BF, DAD, DD, DSA, EI, JWB, RE and TC). One of the WRPs in the charts (TC) showed evidence that the case formulation involved a team process, and the remaining seven (BF, DAD, DD, DSA, EI, JWB and RE) did not.

Recommendation 2 and 3, October 2007:
• Include the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors.
• Update the present status to reflect the current status of these vulnerabilities.

Findings:
ASH used item #6 from the DMH Mall Alignment Monitoring Form (Focuses on the individual's vulnerabilities to mental illness, substance abuse, and readmission due to relapse, where appropriate) to address this recommendation, reporting 51% compliance. The table below with its monitoring indicator showing the number of charts designated for auditing (N), the number of charts actually audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

<table>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean</td></tr>
<tr><td>N</td><td>20</td><td>20</td><td>20</td><td>20</td><td>20</td><td>20</td><td></td></tr>
<tr><td>n</td><td>18</td><td>17</td><td>15</td><td>17</td><td>17</td><td>19</td><td></td></tr>
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%S	90	85	75	85	85	95	
%C #6	50	41	33	65	59	53	51

This monitor reviewed eight charts (BF, DAD, DD, DSA, EI, JWB, RE and TC). Six of the WRPs in the charts (BF, DAD, DSA, JWB, RE and TC) included the individuals' vulnerabilities to mental illness, substance abuse, and readmission due to relapse in the case formulation sections, and where applicable updated the vulnerabilities in the Present Status section of the individual's WRP. Two of the WRPs (DD and EI) did not do so.

Recommendation 4, October 2007:
Develop and implement a training curriculum to ensure proper implementation by WRPTs of the staged model of substance abuse.

Findings:
This monitor's documentation review (Substance Abuse Services Staff Competency, SAS staff licensure certification, Substance Abuse Service employee Competency Training Workbook, Substance Abuse course contents) and interview of the Mall Director found that ASH has developed and implemented a training curriculum for WRPTs on the staged model of substance abuse. According to the Mall Director, the training was offered facility-wide to all WRPTs, and to date 390 staff have received the training.

Recommendation 5, October 2007:
Provide groups regarding the purpose of Wellness and Recovery Action Plan to all individuals in order to preempt relapse.

Findings:
This monitor's review of ASH's progress report found that 66% (132/200) of all individuals in Program IV and 27% (303/1119) of all individuals in the facility over the last six months were enrolled in the

		WRAP program. The Mall Director reported that all individuals are offered the opportunity and encouragement to enroll in the WRAP group. **Current recommendations**: 1. Undertake clinical case formulation as a team rather than by assigning the task to a team member or to non-team members. 2. Include the individual's vulnerabilities in the case formulation under predisposing, precipitating, and perpetuating factors. 3. Update the present status to reflect the current status of these vulnerabilities. 4. Provide groups regarding the purpose of Wellness and Recovery Action Plan to all individuals in order to preempt relapse.
C.2.i.vi	is provided in a manner consistent with each individual's cognitive strengths and limitations;	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** PSR mall groups should address the assessed cognitive levels of the individuals participating in the group. **Findings:** This monitor's documentation review (IAPs, DCAT service log, and Mall Course Contents) and interview of Charles Broderick (Senior Supervising Psychologist, responsible for Psychology Assessments), Christine Mathiesen (Neuropsychologist), and Matt Hennessy (Mall Director) found that ASH identifies individuals' cognitive status at many levels (IAPs, Focused Assessments, and DCAT assessments). According to Charles Broderick, nearly 89% of the individuals in ASH fall in the Challenged category of cognitive functioning. Accordingly, the Mall Director has developed a number of Mall courses for the individuals at this level. These groups include Anger Management, Symptom Management, SVP Tutorial, Ready Set Go, and Substance Abuse-STAR Group.

ASH has also established a sub-committee from the curriculum committee to work on defining mall courses for individuals of all cognitive levels.

The Mall Director has also set up training for group facilitators on learning strategies of individuals at varying cognitive levels. Documentation showed that as of March 26, 2008, 246 staff had attended the Group Facilitator training and 162 staff had attended the Learning Strategies training.

ASH used item #7 from the DMH Mall Alignment Monitoring Form (*Is provided in a manner consistent with each individual's cognitive strengths and limitations*) to address this recommendation, reporting 39% compliance. The table below with its monitoring indicator showing the number of charts designated for auditing (N), the number of charts actually audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
N	20	20	20	20	20	20	
n	9	8	6	10	9	11	
%S	45	40	30	50	45	55	
%C #7	44	25	50	50	44	27	39

This monitor reviewed five charts (ADG, CC, HC, RB and SNA). The groups assigned for three of the individuals' (ADG, CC and HC) were appropriate to their diagnoses, psychological functioning, and cognitive levels, and the groups for the remaining two (RB and SNA) were not well-matched.

Recommendation 2, October 2007:
Psychologists should assess all individuals suspected of having cognitive

		disorders, mental retardation and developmental disabilities and other conditions that may adversely impact an individual's cognitive status. **Findings:** ASH screens cognitive levels of all individuals upon admission through the Integrated Assessments: Psychology Section. The screening includes an intellectual functioning screen, reading and cognitive functioning. The individual is given a full intellectual assessment battery if the screening results in low scores and a neuropsychological assessment if warranted. ASH should consider re-testing an individual's cognitive and/or neurological/neuropsychological status any time the individual evidences significant change in behaviors/functioning. **Current recommendations**: 1. PSR mall groups should address the assessed cognitive levels of the individuals participating in the group. 2. Psychologists should assess all individuals suspected of having cognitive disorders, mental retardation and developmental disabilities and other conditions that may adversely impact an individual's cognitive status.
C.2.i.vii	Provides progress reports for review by the Wellness and Recovery Team as part of the Wellness and Recovery Plan review process;	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Ensure that all group and individual therapy providers provide the WRPTs with progress reports on all individuals prior to each individual's scheduled WRP review. **Findings:** This monitor's document review (Monthly Mall Progress Note Pathway) and interview with the Mall Director and the Clinical Administrator

		found that Monthly Progress Notes are written for Program IV, and quarterly progress notes are written in the rest of the facility. ASH has set in place a process/pathway to ensure that WRPTs receive progress notes in a timely fashion. The electronic progress note system through the WARMSS is still under development. This monitor reviewed eight charts (BF, DAD, DD, DSA, EI, JWB, RE and TC). Progress notes were available in five of the charts (DAD, DD, JWB, RE and TC), and progress notes were not found in the remaining three charts (BF, DSA and EI). **Recommendation 2, October 2007:** Automate this system to make it feasible for the group facilitators and individual therapists to provide progress notes in a timely manner. **Findings:** ASH has yet to complete automation of the WaRMSS system for Mall Progress Notes. Meanwhile, the Mall Director has set up a system/ pathway for collection of the progress notes and delivery to the WRPTs. **Recommendation 3, October 2007:** Use the data from monthly Mall Progress Notes in the WRP review process. **Findings:** This monitor reviewed five charts (DAD, DD, JWB, RE and TC). Two of the WRPs in the charts (DAD and RE) had incorporated information from the Mall Progress Notes into the Present Status section of the individual's WRP, and the remaining three WRPs did not do so (DD, JWB and TC).

		Other findings: Record review of individuals participating in Rehabilitation Therapist-led PSR Mall groups found that 43% had evidence of Mall Facilitator Monthly Progress notes and 43% of progress notes were completed appropriately. Record review of individuals receiving direct Physical and Speech Therapy found that 94% of records contained documentation of progress but none of the records contained documentation of progress in the WRP. **Current recommendations:** 1. Ensure that all group and individual therapy providers provide the WRPTs with progress reports on all individuals prior to each individual's scheduled WRP review. 2. Automate this system to make it feasible for the group facilitators and individual therapists to provide progress notes in a timely manner. 3. Use the data from monthly Mall Progress Notes in the WRP review process.
C.2.i.viii	is provided five days a week, for a minimum of four hours a day (i.e., two hours in the morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on state holidays;	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Provide PSR Mall groups as required by the EP, five days a week, for a minimum of four hours a day (i.e. two hours in the morning and two hours in the afternoon each weekday), for each individual or two hours a day when the individual is in school, except days falling on state holidays. **Findings:** This monitor's documentation review (Mall Schedule) found that ASH now offers Mall groups for five days a week, for four hours a day, with

		two hours in the morning and two hours in the afternoon. The AM Mall hour blocks are from 9:45AM to 10:35AM and 10:50AM to 11:40AM, and the PM Mall hour blocks are from 1:45PM to 2:35PM and from 3:30PM to 4:20PM. **Recommendation 2, October 2007:** Mandate that all staff at ASH, other than those who attend to emergency medical needs of individuals, will provide services at the PSR Mall. This includes clinical, administrative and support staff. **Findings:** This monitor's documentation review (Memorandum) found that the Executive Director has required all staff to enroll in the facilitator training sessions qualifying them to facilitate/co-facilitate Mall groups. According to the Mall Director, all staff are to be signed up for groups when they have completed the training. **Recommendation 3, October 2007:** All Mall sessions should be 50 minutes in length. **Findings:** This monitor's documentation review (Mall Schedule) found that ASH has scheduled all Mall groups for 50 minutes each. The three Mall groups observed by this monitor (Depression and Crisis Management, Symptom Management, and Coping with Anxiety) were conducted for 50 minutes each. This monitor's review of ASH's Provider Consultation Forms found that two of the five groups audited did not conduct the group activity for 50 minutes. **Recommendation 4, October 2007:** Provide groups as needed by the individuals and written in the individuals' WRPs.

		Findings: ASH has developed and implemented the New Activity Form and the Add/Drop Form. The Add/Drop form is for use by the WRPTs to change groups when individuals have difficulty with the level of a group or when a group is not meeting their needs. The New Activity Request form is for use by the WRPTs to request a group(s) that an individual needs but is not included in the Mall catalogue. This monitor's documentation review found that the Mall Director had received five WRP Active Treatment Requests in the last six months. Four of the requests were for services relating to domestic violence, and the fifth was for Post-Traumatic Stress due to military service. **Current recommendations**: 1. Mandate that all staff at ASH, other than those who attend to emergency medical needs of individuals, will provide services at the PSR mall. 2. This includes clinical, administrative and support staff. All Mall sessions should be 50 minutes in length. 3. Provide groups as needed by the individuals and written in the individuals' WRPs.
C.2.i.ix	is provided to individuals in bed-bound status in a manner and for a period that is commensurate with their medical status;	**Current findings on previous recommendation:** **Recommendation 1 and 2, October 2007:** • Ensure that bed-bound individuals are included in the planning and implementation of appropriate activities commensurate with their cognitive status and medical health, and physical limitations. • Therapy can be provided in any physical location within the hospital as long as the services are structured and consistent with scheduled Mall activities. **Findings:** This monitor's visit to the SNF units and interview with the Mall

		Director found that ASH did not have any bed-bound patients at the time of the tour. This monitor observed that individuals with limited mobility and difficulty ambulating were wheelchair-assisted by staff to attend Unit Mall groups. The Mall Director reported that he intends to adapt the existing Mall curriculum/courses for bed-bound individuals. **Current recommendations**: 1. Ensure that bed-bound individuals are included in the planning and implementation of appropriate activities commensurate with their cognitive status and medical health, and physical limitations. 2. Therapy can be provided in any physical location within the hospital as long as the services are structured and consistent with scheduled Mall activities.
C.2.i.x	routinely takes place as scheduled;	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Implement a more focused Mall program that is regularly scheduled, implemented, and provided within the individual's cognitive, medical, physical and functional status. **Findings:** ASH has developed and implemented a number of Mall groups according to cognitive levels (Anger Management, Symptom Management, SVP Tutorial, Ready Set Go, and Substance Abuse-STAR Group). These groups are better aligned with ndividuals' cognitive and functioning levels. The same adaptation for individuals' medical, physical and functional status should be done for all groups. **Recommendation 2, October 2007:** Ensure that Mall groups and individual therapies are cancelled rarely, if ever.

Findings:
This monitor's documentation review (Mall Cancellation data) found that on average, Mall groups were cancelled at an 11% rate each month (range of 6% to 14%).

Recommendation 3, October 2007:
Ensure that all disciplines facilitate a specified minimum number of hours of Mall groups.

Findings:
According to EP guidelines, ASH staff are expected to provide a minimum number of hours of Mall services per week. The number of hours required to be offered per week varies across disciplines, and is as follows:

Discipline	Hours Provided/Week
Psychiatry	8
Psychology	10
Social Work	10
Rehabilitation Therapy	15
Registered Nurses	12
Psychiatric Technicians	12

The table below showing the disciplines and the average hours/per week of Mall services offered by each discipline is a summary of the facility's data:

Job Classification	Average Hours/Week
Clinical Social Worker	3.27
Clinical Dietician	0.77
Psych Tech	1.43

Psychologist	2.24
Registered Nurse	1.05
Rehabilitation Therapist, Art	3.69
Rehabilitation Therapist, Dance	12.95
Rehabilitation Therapist, Music	5.78
Rehabilitation Therapist, Rec.	4.95
Staff Psychiatrist	1.21

As the table above shows, none of the disciplines are providing the minimum expected hours of Mall service per week. The Mall Director reported that many of the staff in each discipline have not completed their training. These staff will sign up for groups as soon as they complete their training.

Recommendation 4, October 2007:
Ensure that administrators and support staff facilitate a minimum of one Mall group per week.

Findings:
Administrative and Support staff in ASH are expected to provide a minimum of one hour of Mall group service per week. This monitor's review of ASH's self-assessment data showed that the following categories of staff were providing over and above the minimum hours of service:

Job Classification	Average Hours/Week
Assistant Chief, CPS	14.21
Clinical Psychology Intern	1.06
Clothing Center Manager	1.15
Custodian	3.71
Graduate Student Assistant	3.21

		<table><tr><td>Health Services Specialist</td><td>1.03</td></tr><tr><td>Program Assistant</td><td>1.10</td></tr><tr><td>Psych Tech Trainee</td><td>1.05</td></tr><tr><td>Social Work Associate</td><td>2.29</td></tr><tr><td>Senior Psych Tech</td><td>1.36</td></tr><tr><td>Senior Psychologist</td><td>1.64</td></tr><tr><td>Supervising Cook</td><td>1.87</td></tr><tr><td>Teacher</td><td>14.36</td></tr><tr><td>Vocational Instructor, Mill and Cab Work</td><td>6.30</td></tr><tr><td>Vocational Instructor, Print-graph</td><td>11.87</td></tr><tr><td>Vocational Instructor, Landscape</td><td>13.86</td></tr></table> All other category of administrative and support staff are not meeting their required minimum of one hour of PSR Mall services. **Current recommendations**: 1. Implement a more focused Mall program that is regularly scheduled, implemented, and provided within the individual's cognitive, medical, physical and functional status. 2. Ensure that Mall groups and individual therapies are cancelled rarely, if ever. 3. Ensure that all disciplines facilitate a specified minimum number of hours of Mall groups. 4. Ensure that administrators and support staff facilitate a minimum of one Mall group per week.
C.2.i.xi	includes, in the evenings and weekends, additional activities that enhance the individual's quality of life; and	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Develop a list of enrichment activities available along with staff names competent in facilitating the activities in accordance with generally accepted professional standards of care.

		Findings: ASH has developed a list of enrichment activities provided in the facility with names of staff competent in facilitating those activities. **Recommendation 2 and 3, October 2007:** • Increase the number of hours of enrichment activities per individual provided in the evenings and weekends. • Ensure that there is uniformity in the methodology and process of how the groups are organized and managed. **Findings:** This monitor's review of ASH's enrichment activities list found that ASH has significantly increased the number and variety of enrichment activities offered in the facility. On average, 1332 activities are offered each month. ASH has assigned a supplemental activities coordinator, Brooke Hatcher, to develop and implement enrichment activities with uniformity in the methodology and process of how the groups are organized and managed. This monitor met with the supplemental activities coordinator. She offered a number of activities she plans to introduce, the first being to audit current activities in order to improve the implementation and methodology of the enrichment activities. **Current recommendations:** 1. Develop a list of enrichment activities available along with staff names competent in facilitating the activities in accordance with generally accepted professional standards of care. 2. Increase the number of hours of enrichment activities per individual provided in the evenings and weekends. 3. Ensure that there is uniformity in the methodology and process of how the groups are organized and managed.

C.2.i.xii

is consistently reinforced by staff on the therapeutic milieu, including living units.

Current findings on previous recommendations:

Recommendation 1, October 2007:
All WRPs should have therapeutic milieu interventions clearly specified in the intervention sections.

Findings:
ASH audited Focus 1 and 11 using charts from Units 2, 3, 9, and 16 on Program IV to address this recommendation, reporting 60% and 90% compliance, respectively. The tables below showing the Foci audited, the number of beds in each unit (N), the number of charts audited from each unit (n), and the percentage of compliance obtained (%C) are summaries of the facility's data.

Focus 11 Intervention

	Unit 2	Unit 3	Unit 9	Unit 16
N	34	23	41	43
n	10	10	10	10
%S	29	43	24	23
%C	30	40	60	60

Focus 1 Intervention

	Unit 6-Admissions
N	33
N	10
%S	30
%C	90

This monitor reviewed eight charts (BF, DAD, DD, DSA, EI, JWB, RE and TLC). Four of the WRPs in the charts (BF, DD, DSA and EI) had developed therapeutic milieu interventions for each active objective,

and the remaining four (DAD, JWB, RE and TLC) did not have therapeutic milieu interventions for one or more active objectives.

Recommendation 2 and 3, October 2007:

- Ensure that unit staff reinforces individuals appropriately during Mall group activities as well as in the units.
- Continue to monitor this requirement.

Findings:

ASH used item #12 from the Therapeutic Milieu Observation Monitoring Form (*Staff is observed discussing mall activities with individuals*) to address this recommendation, reporting 25% compliance. The table below with its monitoring indicator showing the number of units in the hospital (N), the number of audits completed (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
N	29	28	28	26	27	26	27
n	16	24	23	18	16	8	18
%S	55	85	82	69	59	31	64
%C #12	22	25	22	17	38	38	25

This monitor's observation of Mall group activities found that facilitators were frequently and appropriately reinforcing individuals during the activities. This monitor did not observe this process in the units.

Current recommendations:

1. All WRPs should have therapeutic milieu interventions clearly specified in the intervention sections.
2. Ensure that unit staff reinforces individuals appropriately during Mall group activities as well as in the units.

C.2.j	Adequate, individualized group exercise and recreational options are provided, consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendations 1-5, October 2007:** • Establish group exercises and recreational activities for all individuals. • Ensure that there is sufficient activity programming to keep individuals active and engaged. • Provide training to Mall facilitators to conduct the activities appropriately. • Track and review participation of individuals in scheduled group exercise and recreational activities. • Implement corrective action if participation is low. **Findings:** This monitor's documentation review (recreational activity list, participation log, training documentation) found that ASH has developed and implemented facility-wide recreational activities and exercise groups (the list showed 37 new activities) during the weekdays and weekends. According to the Mall Director, plans for an Open Gym are being developed so individuals can choose to engage in recreational activities in the gym. Training for the instructors/facilitators is provided on a monthly basis during the New Employee Orientation "Mall Overview." ASH audited individuals with high BMIs (25 and above) in Program IV to evaluate their participation in recreational activities/exercises, reporting 66% participation. The table below showing the number of individuals' with high BMIs in Program IV (N), the number of individuals' participating regularly in at least one recreational activities/exercise (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

		<table><tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean</td></tr><tr><td>N</td><td>125</td><td>134</td><td>122</td><td>102</td><td>125</td><td>119</td><td></td></tr><tr><td>n</td><td>73</td><td>78</td><td>83</td><td>74</td><td>95</td><td>52</td><td></td></tr><tr><td>%C</td><td>58</td><td>58</td><td>68</td><td>73</td><td>76</td><td>44</td><td>66</td></tr></table> ASH conducts "attendance motivational meetings" twice daily prior to Mall block hours. According to the Mall Director, during these meetings, staff encourages/prompts individuals to attend their scheduled groups/activities, guides them to the setting, and records reasons for those who choose to not attend their scheduled activities. ASH should conduct a facility-wide review of individuals' participation in recreational/exercise groups, and take corrective action if participation is low. **Compliance:** Partial. **Current recommendations**: 1. Establish group exercises and recreational activities for all individuals. 2. Ensure that there is sufficient activity programming to keep individuals active and engaged. 3. Provide training to Mall facilitators to conduct the activities appropriately. 4. Track and review participation of individuals in scheduled group exercise and recreational activities.
C.2.k	Individuals who have an assessed need for family therapy services receive such services in their primary language, as feasible, consistent with generally accepted professional standards of care	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Conduct a needs assessment with individuals and/or their families.

	and that these services, and their effectiveness for addressing the indicated problem, are comprehensively documented in each individual's chart.	**Findings:** This monitor's documentation review (Family Needs Assessment Survey) and interview of the Chief of Social Work found that ASH sent the Survey to family members of individuals in Program IV. According to the available information, 28 surveys were returned and the summary of information from those surveys revealed that 84% of family members indicated a need for family therapy/education services. In addition: • 53% indicated that they were familiar with the process of contacting their family member(s) admitted at ASH. • 50% indicated an interest in participating in the WRPC; only one reported having had an invitation to participate in the WRPC. • 100% of the respondents indicated that they had little to no knowledge of the discharge plans for their family member(s) at ASH. The results of the survey are telling (strengths and deficits). ASH should take steps to ameliorate some of the deficits (for example, invitation to WRPCs and updating families on the discharge plans). **Recommendation 2 and 3, October 2007:** • Use individual discharge plan goals as a way to identify families that may need family therapy to help them assist and support their family members upon discharge. • Review pre-admission reports and services/treatments provided to identify the need for family therapy services. **Findings:** This monitor's review of information from the Family Therapy Needs Survey and the Chief of Social Work indicates that ASH is using the Family Therapy Needs Survey and Item #4 from the DMH 30-Day

		Psychosocial Assessment tool to identify the need for family therapy services. Proper and consistent use of these mechanisms should capture almost all families that are in need of such services. **Recommendation 4, October 2007:** Ensure that family therapy needs are fulfilled. **Findings:** This monitor's interview of the Chief of Social Work found that the Statewide Social Work Chiefs are brainstorming on the various methods that can be employed to address Family Therapy and Education needs. **Compliance:** Partial. **Current recommendations:** 1. Continue with the Family Therapy Needs Assessment Survey. 2. Ensure that family therapy needs are fulfilled.
C.2.l	Each individual's therapeutic and rehabilitation service plan identifies general medical diagnoses, the treatments to be employed, the related symptoms to be monitored by nursing staff (i.e., registered nurses ["RNs"], licensed vocational nurses ["LVNs"] and psychiatric technicians) and the means and frequency by which such staff shall monitor such symptoms, consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendations 1 and 2, October 2007:** • Implement a monitoring system to track the elements of this requirement. • Provide data addressing this requirement. **Findings:** ASH's progress report indicated that the statewide DMH Integration of Medical Conditions tool was developed and will be used for data collection for the next review. No data regarding this requirement was collected for this review.

		Compliance: Partial. **Current recommendations**: 1. Implement the statewide monitoring tool to track the elements of this requirement. 2. Provide data addressing this requirement.
C.2.m	The children and adolescents it serves receive, consistent with generally accepted professional standards of care:	The requirements of Section C.2.m are not applicable because ASH does not serve children and adolescents.
C.2.m.i	Therapy relating to traumatic family and other traumatic experiences, as clinically indicated; and	
C.2.m.ii	reasonable, clinically appropriate opportunities to involve their families in treatment and treatment decisions.	
C.2.n	Policies and procedures are developed and implemented consistent with generally accepted professional standards of care to ensure appropriate screening for substance abuse, as clinically indicated.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Implement AD #414.1 regarding Screening and Assessment for Substance Abuse Disorders for all individuals at ASH. **Findings:** ASH has implemented AD #414.1 in the admission units and efforts are underway for hospital-wide implementation. The facility has developed a plan to track all individuals with substance abuse diagnoses throughout their hospital stays and to establish these individuals' stages of change within seven days of admission to facilitate implementation.

		Compliance: Partial. **Current recommendations:** Implement AD #414.1 regarding Screening and Assessment for Substance Abuse Disorders hospital-wide.
C.2.o	Individuals who require treatment for substance abuse are provided appropriate therapeutic and rehabilitation services consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Increase and strengthen training of WRPTs and SAS providers to improve assessment by the teams of the stages of change and the development of corresponding specific and individualized objectives and interventions. **Findings:** Since the last review, ASH has increased training regarding this requirement. The following is an outline of the training provided during the review period: 1. WRP overview training was provided as discussed in C.1.a. This training addresses the principles of the stages of change model. 2. Specific training course titled "Recovery Stages of Change" was provided to all new employees who will deliver direct care to individuals as well as employees who had missed the training during the prior reporting period. The training is a 90-minute overview of the Stages of Change that defines the stages of change model and covers the implications for assessment, treatment planning, and Mall interventions. The facility also plans to continue the four-hour training based on SAMSHA's Tip 35, specific to the pre-contemplative stage, formally

		titled Enhancing Motivation in Pre-Contemplative Substance Abusers as new providers for pre-contemplative substance abuse services are needed. This training was not needed during this review period ASH has strengthened the stages of change training material in the last reporting period through development of example objectives tied to the stages of change for Substance Abuse Services Mall courses. Additionally, new course descriptions defining all SAS courses were developed and distributed to WRPTs. **Recommendations 2, October 2007:** Provide specific data regarding the facility's system of assessing clinical outcomes and results of this assessment. **Findings:** ASH reported that it utilizes a system of clinical outcomes that is based on the following: 1. Upward movement of individuals throughout the stages of the change; and 2. The use of pre- and post-tests that are administered at the beginning and conclusion of group cycles. This system is adequate to assess clinical outcomes. ASH did not provide data regarding these outcomes **Recommendation 3, October 2007:** Continue to track process outcomes regarding substance abuse services. **Findings:** ASH currently utilizes the process outcomes that were listed in the previous report. The facility did not provide data regarding these

outcomes compared to the last review.

Recommendation 4, October 2007:
Collaborate with MSH to integrate indicators regarding SAS clinical and process outcomes.

Findings:
ASH has implemented this information.

Recommendation 5, October 2007:
Provide data to demonstrate that individuals under PC 1370 and PC 2684 are receiving substance abuse services based on their assessed needs.

Findings:
ASH reported that 32 individuals under these commitment categories are currently enrolled in substance abuse services. The facility did not specify the number of individuals in this category who need these services.

Other findings:
ASH used the newly standardized DMH WRP Substance Abuse Monitoring Form to assess compliance (January and February 2008). The sample was 100% of the individuals in Program IV who have an Axis I Substance Abuse Diagnosis. The following is an outline of the indicators and corresponding mean compliance rates:

1.	*Substance abuse is integrated into the case formulation and discussed in the present status*	49%
2.	*There is an appropriate Focus statement listed under Focus #5*	78%
3.	*There is at least one objective related to the individual's stage of change*	42%

		4.	*There are interventions that are appropriately linked to the active objective(s)*	21%
		5.	*The active treatment for substance abuse that is specified in the WRP is aligned with the individual's mall schedule*	43%
		6.	*The discharge criteria related to substance abuse are individualized and written in behavioral, observable and/or measurable terms*	14%

This monitor reviewed the charts of six individuals diagnosed with substance use disorders (EVF, MJP, ODM, RLW, TH and VL). The reviewed showed found the following pattern was noted:

1. Substance abuse was listed as a diagnosis on the WRP in all cases except one (RLW).
2. All charts included focus, objective(s) and intervention(s) related to substance abuse.
3. The objectives and interventions were not properly linked to the stages of change in all charts reviewed.

Compliance:
Partial.

Current recommendations:
1. Increase and strengthen training of WRPTs and SAS providers to improve assessment by the teams of the stages of change and the development of corresponding specific and individualized objectives and interventions.
2. Provide data regarding clinical outcomes.
3. Provide data regarding process outcomes in comparison to the last review period.
4. Monitor this requirement using the DMH Substance Abuse Auditing Form and provide data analysis that delineates and evaluates areas

<table>
<tr><td></td><td></td><td>of low compliance and relative improvement (during the reporting period and compared to the last period).</td></tr>
<tr><td>C.2.p</td><td>Group facilitators and therapists providing therapeutic and rehabilitation services (in groups or individual therapy) are verifiably competent regarding selection and implementation of appropriate approaches and interventions to address therapeutic and rehabilitation services objectives, are verifiably competent in monitoring individuals' responses to therapy and rehabilitation, and receive regular, competent supervision.</td><td>Current findings on previous recommendation:

Recommendation 1 and 2, October 2007:
• Assess the competency of group facilitators and therapists in providing rehabilitation services.
• Ensure that facilitators evaluate individuals' responses to therapy and rehabilitation and use the data to modify teaching and training of individuals to achieve their goals and objectives.

Findings:
ASH assesses provider competency through the use of the PSR Mall Facilitator Consultation Checklist and observation and supervision by senior clinicians. According to the Mall Director and the Clinical Administrator, Mall group facilitators are also evaluated through the privileging/credentialing process.

The table below (this monitor modified ASH's original table by collapsing the 24 ratings/questions into their four categories) showing the total Mall hours offered each month (N), the hours of observation conducted using the WRP Mall Facilitator Audit Form (n), and the percentage of compliance obtained in each category (%C) is a summary of the facility's data.

<table>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean</td></tr>
<tr><td>N</td><td>3797</td><td>5035</td><td>4978</td><td>3477</td><td>4195</td><td>5066</td><td>4425</td></tr>
<tr><td>n</td><td>13</td><td>5</td><td>8</td><td>0</td><td>4</td><td>6</td><td>6</td></tr>
<tr><td>%S</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>%C</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
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<tr><td>Course Structure</td><td></td><td></td><td></td><td></td><td></td><td></td><td>78</td></tr>
<tr><td>Instructional Techniques</td><td></td><td></td><td></td><td></td><td></td><td></td><td>40</td></tr>
<tr><td>Learning Process</td><td></td><td></td><td></td><td></td><td></td><td></td><td>60</td></tr>
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The sub-items (not presented in the table) in the category "Instructional Technique" in the table above, with 40% aggregate compliance, capture the facilitator's activity (shaping, role-playing, prompting, homework) in addressing the individuals' responses to therapy and rehabilitation and using the data to modify teaching and training of individuals to achieve their goals and objectives. The facility's data is in agreement with this monitor's Mall group observation.

Compliance:
Partial.

Current recommendations:
1. Assess the competency of group facilitators and therapists in providing rehabilitation services.
2. Ensure that facilitators evaluate individuals' responses to therapy and rehabilitation and use the data to modify teaching and training of individuals to achieve their goals and objectives.
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<tr>
<td>C.2.q</td>
<td>Group facilitators and therapists providing therapeutic and rehabilitation services in the field of substance abuse should be certified substance abuse counselors.</td>
<td>Current findings on previous recommendations:

Recommendation 1, October 2007:
Ensure that all group facilitators complete the substance abuse training curriculum as per ASH training curriculum.</td>
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		Findings: This monitor's documentation review (Substance A course outline, Substance Abuse curriculum, Substance Abuse Service Employee Competency Training Workbook, Substance Abuse Focus 5 Activity Outline for all five stages of change, Substance Abuse Services Staff Competency) and interview with the Clinical Administrator and the Standards Compliance Director found that Substance Abuse group facilitators in ASH are licensed/certified to California State standards or to the approved ASH certification standards. (The ASH certification standards are reported to parallel the community standards.) **Recommendation 2 and 3, October 2007:** • Clarify and streamline staff competency criteria to ensure their alignment with the current training curriculum. • Ensure that training includes all of the five stages of change. **Findings:** This monitor's documentation review (Substance Abuse Services Employee Training Workbook, Focus 5 Activity List) is in agreement with the facility's report that the competency criteria are aligned with the training curriculum. Both the workbook and the Focus 5 Activity list include the five stages of change. **Recommendation 4, October 2007:** Establish a review system to evaluate the quality of services provided by these trained facilitators. **Findings:** This monitor's interview with the Clinical Administrator and documentation review found that ASH is using the "PSR Mall Course Facilitator Consultation" form to evaluate the quality of Mall provider services provided.

		Recommendation 5, October 2007: Ensure that providers serving individuals at the pre-contemplative stage are trained to competency and meet ASH substance abuse counseling competency. **Findings:** This monitor interviewed the Mall Director. According to the Mall Director, all staff providing substance abuse pre-contemplation groups have been trained to competency in stage of change dynamics and objectives. This monitor reviewed the training documentation (training was conducted in August 31, 2007, and September 27, 2007) for staff providing services at the pre-contemplative stage and is in agreement with the Mall Director's report. **Compliance:** Substantial. **Current recommendations**: 1. Ensure that all group facilitators complete the substance abuse training curriculum as per ASH training curriculum. 2. Evaluate and report the quality of services provided on Substance Abuse by the trained facilitators. 3. Ensure that providers serving individuals at the pre-contemplative stage are trained to competency and meet ASH substance abuse counseling competency.
C.2.r	Transportation and staffing issues do not preclude individuals from attending appointments.	**Current findings on previous recommendations:** **Recommendation 1 and 2, October 2007:** • Establish an automated system to track cancellation of scheduled appointments. • Continue to ensure that all medical appointments of individuals are

completed as scheduled.

Findings:
According to the Director of Standards Compliance and the Mall Director, a statewide work group is working to develop an Appointment Scheduler to track appointments kept and cancelled. The work is yet to be completed. In the interim, ASH is using the Central Medical Services Database for tracking the requirements of this recommendation.

ASH audited appointment cancellations using the Medical Appointment Tracking system, reporting seven cancellations out of 857 scheduled appointments over a six-month period. Five of the seven cancelled appointments were due to transportation issues. The table below is a summary of the facility's data.

Month	Appointments Completed	Appointments Cancelled	Reasons for Cancellation
9/07	97	5	Five due to transportation issue--Handicap Van breakdown.
10/07	156	1	One due to court related matter.
11/07	110	0	
12/07	161	1	One due to court related matter.
1/08	170	0	
2/08	156	0	

There were 512 scheduled appointments with four cancellations in the October 2007 review.

		Compliance: Partial. **Current recommendations**: 1. Establish an automated system to track cancellation of scheduled appointments. 2. Continue to ensure that all medical appointments of individuals are completed as scheduled.
C.2.s	Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse, are appropriately addressed, consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Ensure that individuals' cognitive levels, needs, and strengths are utilized when considering group assignments. **Findings:** The WRPTs have information on individuals' cognitive functioning, especially now that ASH has completed review/screening/assessment of all individuals in the facility. ASH has implemented a few Mall groups with curriculums and courses suitable for individuals in the challenged cognitive level. According to the Mall Director, other groups for different cognitive levels are to be developed and implemented. This monitor reviewed eight charts (AS, CC, DL, DS, GEP, JG, MG and RH). The WRPs in these charts showed that the group assignments were meaningful relative to the individuals' identified needs. However, the individuals were not assigned for 20 hours of PSR services, strengths were not documented in the interventions or the stated strengths were not of acceptable quality, and life goals were not linked to a focus of hospitalization with appropriate objectives, interventions, and associated with a Mall group.

		Recommendation 2, October 2007: Ensure that providers and facilitators are knowledgeable, competent, and motivated to translate course content to individuals' needs to maximize learning. **Findings:** This monitor's documentation review (PowerPoint presentations, handouts, lesson plans, course contents) found that the Mall Director and his staff have developed and distributed a number of tools for Mall facilitator use. In addition, training documentation showed that training on teaching individuals with cognitive challenges was provided (groups facilitator training, Learning Strategies). Furthermore, Jan-Marie Alarcon, ASH's Master Trainer, has put together a number of excellent tools to aid facilitators and WRPT members (for example, Interventions and Mall Integration). This monitor's review of ASH's data from Mall Facilitator Audit Form (data presented in table under C.2.p) found that of the facilitators audited obtained 92% on Instructional Skills and 40% on Instructional Techniques. **Recommendation 3, October 2007:** Develop and implement monitoring systems that address all of the required elements. **Findings:** ASH audited charts from Program IV, using item #10 (*Adequate oversight to treatment, rehabilitation and enrichment groups is provided to ensure that individuals are assigned to groups that are appropriate to their assessed needs, that groups are provided consistently and with appropriate frequency, and that issues particularly relevant for this population, including the use of psychotropic medications and substance abuse, are appropriately*

addressed, consistent with generally accepted professional standards of care) from the DMH WRP Clinical Chart Audit to address this recommendation, reporting 6%, 1%, and 12% compliance respectively. The table below with its monitoring indicators showing the number of WRPs due each month in Program IV (N), the number of WRPs audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

#10a: The individual's cognitive functioning level, needs, and strengths (as documented in the case formulation) are aligned with the group assignments.

#10b: For each Axis I, II and III diagnoses, the interventions are related to excesses and deficits associated with each diagnosis.

#10c: All interventions are offered at the cognitive functioning level of the individual.

	Oct	Nov	Dec	Jan	Feb	Mean
N	148	143	149	154	147	
n	126	118	114	122	123	
%S	85	83	77	79	84	
%C #10a		2	0	12	8	6
%C #10b		0	0	1	2	1
%C #10c		11	13	16	8	12

This monitor reviewed ten charts (ADG, AH, DJB, EO, JW, LT, LW, RT, SRB and WM). None of the charts met all of the required elements.

Recommendation 4, October 2007:
Continue the implementation of PSR Mall in all programs in the facility.

		Findings: ASH currently offers PSR Mall group services in the form of Central Malls, Unit Malls, Clinical Treatment Areas, and Activity Centers. This monitor's documentation review found that the Mall Director has prepared Procedure Manuals for each type of Mall group service organization. ASH is continuing to fade in PSR Mall to all programs in the facility. According to the Mall Director's plan, ASH will offer PRS Mall groups in all Programs by August 2008. **Compliance:** Partial. **Current recommendations**: 1. Ensure that individuals' cognitive levels, needs, and strengths are utilized when considering group assignments. 2. Ensure that providers and facilitators are knowledgeable, competent, and motivated to translate course content to individuals' needs to maximize learning. 3. Develop and implement monitoring systems that address all of the required elements. 4. Continue the implementation of PSR Mall in all programs in the facility.
C.2.t	Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally-defined target variables and revised as appropriate in light of significant developments, and the individual's progress, or lack thereof;	**Current findings on previous recommendations:** **Recommendation 1 and 2, October 2007:** • Develop and implement monitoring tools to ensure the process outcomes of treatment and/or rehabilitation services. • Develop and implement monitoring tools to ensure that Mall activities are properly linked to the foci, objectives and interventions specified in the WRP.

Findings:
ASH audited Program IV, using item #11 (*Treatment, rehabilitation and enrichment services are monitored appropriately against rational, operationally defined target variables and revised as appropriate in light of significant developments, and the individual's progress, or lack thereof*) from the DMH WRP Clinical Chart Audit Form, to address this recommendation. The table below with its monitoring indicators showing the number of WRPs due each month (N), the number of WRPs audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

#11a: Each objective is observable, measurable and behavioral.

#11b: All groups and individual therapies are linked directly to the foci, objective and interventions specified in the individual's WRP.

#11c: There is a DMH PSR Mall Facilitator Monthly Progress Note for each active treatment in the individual's WRP.

#11d: If the individual has not made progress on an objective in 2 months, the objective and/or intervention is revised, or there is documentation of clinically justifiable reasons for continuing with the objective.

#11e: If the individual has met the objective, a new objective and related interventions have been developed and implemented.

	Oct	Nov	Dec	Jan	Feb	Mean
N	148	143	149	154	147	
n	126	118	114	122	123	
%S	85	83	77	79	84	
%C #11a		13	6	11	26	14
%C #11b		3	1	5	16	6

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<tr><td>%C #11c</td><td></td><td>1</td><td>0</td><td>3</td><td>7</td><td>3</td></tr>
<tr><td>%C #11d</td><td></td><td>1</td><td>7</td><td>5</td><td>4</td><td>4</td></tr>
<tr><td>%C #11e</td><td></td><td>3</td><td>11</td><td>2</td><td>4</td><td>5</td></tr>
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This monitor reviewed 15 charts (ADG, AH, DD, EO, JIL, LT, LW, MDW, MM, MR, MW, SRB, SW, TC and WTM). None of the charts included all the elements to meet criteria for this recommendation. None of the charts contained all required progress notes; none of the WRPs in the charts documented the individual's progress or lack of progress in PSR Mall services; none of the charts contained revised objectives according to the individuals' progress or lack of progress in his/her PSR services or gave reasons for continuing with the objective.

Compliance:
Partial.

Current recommendations:
1. Develop and implement monitoring tools to ensure the process outcomes of treatment and/or rehabilitation services.
2. Develop and implement monitoring tools to ensure that Mall activities are properly linked to the foci, objectives and interventions specified in the WRP.
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<td>C.2.u</td>
<td>Individuals are educated regarding the purposes of their treatment, rehabilitation and enrichment services. They will be provided a copy of their WRP when appropriate based on clinical judgment.</td>
<td>Current findings on previous recommendations:

Recommendation 1, October 2007:
Increase Mall groups to address this requirement.

Findings:
ASH's data indicated that the number of individuals enrolled in the Mall course entitled "Introduction to Wellness and Recovery Planning" has been essentially unchanged since the last review period. However, the facility has reportedly revised this course in favor of a new curriculum</td>
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		for a "Sponsor Group." The new curriculum reportedly will focus both on educating individuals regarding their WRPs and increasing individuals' involvement in the WRP process. ASH plans to complete hospital-wide training and implement the new Sponsor Group curriculum by the end of August 2008. **Recommendation 2, October 2007:** Develop and implement a monitoring tool to address this requirement. **Findings:** ASH did not address this recommendation. **Recommendation 3, October 2007:** Provide data to support that that individuals are provided a copy of the WRP based on clinical judgment. **Findings:** ASH reports that it collected such data, but the data was not presented to the Court Monitor as part of the WRP Observation audit. **Compliance:** Partial. **Current recommendations**: 1. Provide data regarding each group that addresses this requirement, including the hours offered and the number of individuals attending and compare to the last review period. 2. Provide monitoring data related to this requirement. 3. Provide data to support that individuals are provided a copy of their WRPs based on clinical judgment.
C.2.v	Staff educates individuals about their medications, the expected results, and the potential common	**Current findings on previous recommendations:**

	and/or serious side effects of medications, and staff regularly asks individuals about common and/or serious side effects they may experience.	**Recommendations 1 and 2, October 2007:** • Increase the number of Mall groups that offer education regarding medication management facility-wide. • Monitor implementation of this requirement. **Findings:** ASH reported that on Program IV, 197 hours of medication management education were scheduled on average each month during this review period (September 2007 to February 2008) and that 110 hours were actually held on average each month. The data showed that the number of individuals participating in these groups has increased by 49% (176 in February 2008 compared to 118 in August 2007). However, the data regarding scheduled vs. held hours showed that 44% of these groups hospital-wide were not held as scheduled during this reporting period. This rate was three times that of the hospital-wide rate (14%) for all groups. ASH will identify the barriers to facilitators holding their Medication Management groups as scheduled and develop a plan to have these groups held as scheduled. **Compliance:** Partial. **Current recommendations:** 1. Provide data regarding the number of groups scheduled and held compared to the last review period. 2. Increase scheduled groups and implement corrective actions to ensure that scheduled groups are held.
C.2.w	Interdisciplinary teams review, assess, and develop positive clinical strategies to overcome individual's barriers to participation in therapeutic and rehabilitation services.	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Provide Key Indicator data regarding individuals' non-adherence to interventions in the WRP.

		Findings: ASH has implemented this recommendation. **Recommendation 2, October 2007:** Assess barriers to individuals' participation in their WRPs and provide strategies to facilitate participation. **Findings:** ASH has identified that the non-adherence trigger was firing inaccurately due to delinquent MAPP rosters. To address this, the facility has reportedly revised the MAPP process to increase timeliness and accuracy. The development, tracking and data entry of all MAPP rosters is now centralized through RMS. RMS has developed a plan to facilitate compliance with this requirement. This plan reportedly includes delineation of staff responsibilities regarding gathering of data on individuals not participating in the Mall groups and facilitation of Mall motivation meetings with individuals. **Recommendation 3, October 2007:** Provide Motivational Interviewing, Narrative Restructuring Therapy and other cognitive behavioral interventions to individuals who refuse to attend groups as specified in their WRPs. **Findings:** ASH reported that consultants (Dr. Judy Singh and Dr. Robert Wahler) trained three staff in September 2007 and that trained staff worked with four individuals before leaving this program after five months. The consultants trained three additional staff in February 2008 and these staff members are currently working with three individuals.

		Compliance: Partial. **Current recommendations**: 1. Implement corrective actions to address barriers towards individuals' participation in their WRPs, including Mall groups. 2. Provide Motivational Interviewing, Narrative Restructuring Therapy and other cognitive behavioral interventions to individuals who refuse to attend groups as specified in their WRPs.

D. Integrated Assessments		
D	Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual shall receive, promptly after admission to each State hospital, an accurate and comprehensive assessment of the conditions responsible for the individual's admission, to the degree possible given the obtainable information at the time of admission. Thereafter, each individual shall receive an accurate and comprehensive reassessment of the reasons for the individual's continued hospitalization whenever there has been a significant change in the individual's status, or a lack of expected improvement resulting from clinically indicated treatment. The individual's interdisciplinary team shall be responsible for investigating the past and present medical, nursing, psychiatric, and psychosocial factors bearing on the individual's condition, and, when necessary, for revising assessments and therapeutic and rehabilitation plans in accordance with new information that comes to light. Each State hospital shall monitor, and promptly address deficiencies in the quality and timeliness of such assessments.	**Summary of Progress on Psychiatric Assessments and Diagnoses:** 1. ASH has increased psychiatric staffing levels and complied with the staffing ratios required by the EP. 2. ASH has made progress in the frequency and content of weekly psychiatric progress notes (Program IV). 3. ASH has implemented monitoring using the DMH standardized tools regarding the admission, integrated and inter-unit transfer assessments and progress notes (weekly and monthly). **Summary of Progress on Psychological Assessments:** 1. ASH completed all reviews/re-evaluations of IAPs of individuals who were admitted to the facility before June 1, 2006. 2. There was a significant increase in the number of behavioral guidelines developed and implemented. 3. The facility finalized and implemented all applicable documents that codify the requirements of the EP. **Summary of Progress on Nursing Assessments:** 1. ASH has implemented the Statewide Nursing Admission and Integrated Assessments. 2. The Nursing Admission Assessments have been completed in a timely manner. **Summary of Progress on Rehabilitation Therapy Assessments:** 1. The Integrated Assessment- Rehabilitation Therapy Services (IA-RTS) admission assessment has been revised and implemented to ensure that assessments include clinical observations and structured activities, and are multi-disciplinary in nature. 2. Drafts of focused assessments for Occupational, Speech, and Physical Therapy and Vocational Rehabilitation have been developed and are pending finalization and implementation.

		3. Integrated Assessment- Rehabilitation Therapy Section and focused assessment tools appear to meet the requirements of the Enhancement Plan. **Summary of Progress on Nutrition Assessments:** 1. According to interview, trend analysis of Nutrition Care Monitoring data is completed quarterly to identify group and individualized trends. Trend-based mentoring and training continues to be provided to RD's individually and at staff meetings (applies to D5a-D5j.ii). 2. The Nutrition Care Assessment Monitoring Tool criteria have been revised since the last review in order to improve quality of goals (NCMT #10) and recommendations (NCMT #11). Therefore, compliance in these areas has decreased secondary to more specific monitoring criteria, but quality appears to have improved. 3. Specific training for goals (NCMT #10) and recommendations (NCMT #11) was provided in December 2007 to improve compliance in these areas. According to facility report, the plan is to continue focused training in these areas over the next reporting period. 4. According to interview, timeliness of assessments continues to be in poor compliance, most significantly in regards to type D.5.i. (Nutrition Care Updates) and D.5.jii. (Annual assessments) secondary to decreased staffing. **Summary of Progress on Social History Assessments:** Significant opportunities remain to improve the timeliness, comprehensiveness, quality and accuracy of ASH's Social History Assessments. **Summary of Progress on Court Assessments:** ASH has achieved substantial compliance with EP requirements.

1. Psychiatric Assessments and Diagnoses		
	Each State hospital shall provide all of the individuals it serves with routine and emergency psychiatric assessments and reassessments consistent with generally accepted professional standards of care; and,	**Methodology:** Interviewed: Jean Dansereau, MD, Chief of Psychiatry Reviewed: 1. The charts of the following 48 individuals: AA, AD, AE, AJ, ALC, BO, CC, CDB, CEG, CP, CV, DRD, DRL, EF, EW, GEH, GP, GRL, IZ, JDI, JK, JKC, JLF, JT, LB, LH, MAC, MEB, MEW, MJC, MR, MTF, PH, PRI, REO, RLW, RS-2, RSP, SMB, SR, TBR, TH, THT, TLW, VL, WDB, WST and ZDS 2. ASH Admission Medical Evaluation and Treatment Monitoring Form 3. ASH Admission Medical Evaluation and Treatment Monitoring summary data (September 2007 to February 2008) 4. DMH Admission Psychiatric Assessment Auditing Form 5. DMH Admission Psychiatric Assessment Auditing Form Instructions 6. ASH Admission Psychiatric Assessment Auditing summary data (December 2007 to February 2008) 7. DMH Integrated Assessment: Psychiatry Section Auditing Form 8. DMH Integrated Assessment: Psychiatry Section Auditing Form Instructions 9. ASH Integrated Assessment: Psychiatry Section Auditing summary data (December 2007 to February 2008) 10. DMH Weekly Psychiatric Progress notes Auditing Form 11. DMH Weekly Psychiatric Progress notes Auditing Form Instructions 12. ASH Weekly Psychiatric Progress Notes summary data (February 2008) 13. DMH Monthly Psychiatric Progress Notes Auditing Form 14. DMH Monthly Psychiatric Progress Notes Auditing Form Instructions 15. ASH Monthly Psychiatric Progress Notes Auditing summary data

		(January and February 2008) 16. DMH Physician Inter Unit Transfer Note Auditing Form 17. DMH Physician Inter Unit Transfer Note Auditing Form Instructions 18. ASH Physician Inter Unit Transfer Auditing summary data (February 2008)
D.1.a	Each State hospital shall use the diagnostic criteria in the most current Diagnostics and Statistical Manual of Mental Disorders ("DSM") for reaching the most accurate psychiatric diagnoses.	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Finalize statewide efforts to consolidate and standardize monitoring instruments regarding psychiatric initial, integrated and transfer assessments and reassessments. **Findings:** The DMH has developed and finalized the indicators and operational instructions for the following instruments: 1. DMH Admission Psychiatric Assessment Auditing Form; 2. DMH Integrated Assessment: Psychiatry Section Auditing Form; and 3. DMH Physician Inter Unit Transfer Note Auditing Form The indicators and instructions are appropriate to requirements of the EP. The DMH has yet to finalize a standardized tool regarding the Admission Medical Assessment. **Recommendations 2 and 3, October 2007:** • Continue to monitor this requirement based on sample sizes of at least 20% of the total target populations. • Provide monitoring data regarding diagnostic accuracy in the initial and integrated assessments as well as reassessments (progress notes).

Findings:
ASH used the DMH Admission and Integrated Psychiatric Assessment and Monthly Physician Progress Note Audit Forms to assess compliance (December 2007 to February 2008). The average samples were 30%, 76% and 6%, respectively (Program IV). The following is an outline of the indicators and corresponding mean compliance rates:

Admission Assessment	
DSM-IV diagnosis consistent with history and presentation	88%

Integrated Assessment	
Includes psychiatric history, including a review of present and past history	32%
Includes diagnostic formulation	21%
Includes differential diagnosis	82%
Includes current psychiatric diagnoses	84%

Monthly progress notes	
The note includes the 5-Axis diagnosis and this is consistent with the current presentation and recent developments	35%
Current diagnosis (changes, if any, with evidence to support. Includes resolution of NOS, deferred, and rule-out	55%

ASH's data resulted in compliance rates that were comparable to the last review period regarding the Admission Assessment and the Monthly Progress Notes (the facility initiated monitoring for the Integrated Assessment during this review period). To improve compliance, ASH reported a plan to implement the Psychiatric Quality Profile (PQP) to provide ongoing feedback and mentoring by Senior Psychiatrists. The facility also plans to expand monitoring to include all admission units for the admission assessments (effective March 1, 2008) and to implement the integrated psychiatric assessment in

		Program V starting May 1, 2008. **Recommendation 4, October 2007:** Provide ongoing feedback and mentoring by senior psychiatrists to correct the deficiencies outlined by this monitor (D.1.c.i through D.1.c.iii). **Findings:** During this review period, ASH has initiated a process of feedback to the attending psychiatrists by way of returning the admission and integrated assessment with a copy of the monitoring review and noted deficiencies. **Other findings:** Chart reviews by this monitor found that several Admission Psychiatric Assessments were adequate in format and content and that the psychiatric diagnoses were, in general, stated in terminology that is consistent with the current version of DSM. The facility has implemented the Integrated Psychiatric Assessment on Program IV during this review period. However, a pattern of significant deficiencies was noted in the admission and integrated assessments (see D.1.c.ii and D.1.c.iii) that must be corrected to achieve substantial compliance with this requirement. **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using the DMH Admission Assessment, Integrated Psychiatric Assessment and Monthly Progress Note auditing forms based on at least a 20% sample. 2. Provide data analysis that delineates and evaluates areas of low compliance and relative improvement (during the reporting period

		and compared to the last period).
D.1.b	Each State hospital shall ensure that all psychiatrists responsible for performing or reviewing psychiatric assessments:	Please see sub-cells for compliance findings.
D.1.b.i	are certified by the American Board of Psychiatry and Neurology ("ABPN") or have successfully completed at least three years of psychiatry residency training in an Accreditation Counsel for Graduate Medical Education accreditation program, and	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Continue aggressive recruitment efforts to ensure adequate staffing in accordance with the required psychiatrist-to-individual ratios in admission and long-term units. **Findings:** ASH has implemented this recommendation. During this review period, the facility has increased psychiatric staffing to the current level of nearly 50 FTE psychiatrists providing direct clinical services, of whom 38 are contract employees and 11 are civil service employees. This level has allowed the facility to comply with the staffing ratios required by the EP in the admission and non-admission units. All psychiatrists at the facility are currently in compliance with the requirement regarding completion of residency training. The facility has continued its recruitment efforts to ensure that all vacancies are filled and that compliance is maintained. **Recommendation 2, October 2007:** Encourage all psychiatrists to obtain board certification. **Findings:** ASH encourages all psychiatrists to obtain board certification through salary incentives and approved time off for education and examination. The facility did not provide data regarding the number of psychiatrists are currently board-certified.

		Compliance: Substantial. **Current recommendations**: 1. Continue recruitment efforts to ensure that vacancies are filled and staffing ratios are maintained. 2. Provide data regarding the number of psychiatrists who are currently board-certified compared to the last reporting period.
D.1.b.ii	Are verifiably competent (as defined by privileging at initial appointment and thereafter by reprivileging for continued appointment) in performing psychiatric assessments consistent with each State Hospital's standard diagnostic protocols.	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Implement the Psychiatric Physician Quality Profile Program and utilize data in the processes of reprivileging and performance improvement. **Findings:** ASH has yet to implement this recommendation. The facility plans to begin implementation on April 1, 2008. **Recommendation 2, October 2007:** Ensure that the Department of Psychiatry Procedure Manual includes clear performance expectations regarding the format and content of all assessments and reassessments as required by the EP. **Findings:** ASH did not address this recommendation. **Compliance:** Partial. **Current recommendations**: 1. Implement the Psychiatric Physician Quality Profile Program and

		utilize data in the processes of reprivileging and performance improvement. 2. Ensure that the Department of Psychiatry Procedure Manual includes clear performance expectations regarding the format and content of all assessments and reassessments as required by the EP.
D.1.c	Each State hospital shall ensure that:	Please see sub-cells for compliance findings.
D.1.c.i	Within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Medical Assessment that includes:	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Monitor specific requirements of the EP in D.1.c.i.1 through D.1.c.i.5. **Findings:** ASH used the current ASH Admission Medical Evaluation and Treatment Monitoring Form (September 2007 to February 2008). The average sample was 32% of admissions and the mean compliance rate for this requirement was 99%. The mean compliance rates for the requirements in D.1.c.i.1 to D.1.c.i.5 are reported in each corresponding cell below. **Recommendations 2 and 3, October 2007:** • Clarify facility's expectation regarding performance of genital/rectal examination of individuals and ensure alignment with generally accepted professional standards. • Ensure adequate documentation of subsequent attempts to complete the physical examination for individuals who refuse parts or all of the examination and follow-up by the WRPT, as appropriate, for individuals who continue to refuse.

		Findings: The current draft of ASH Medical Policy (see F.7) addresses these recommendations. **Other findings:** This monitor reviewed the charts of 10 individuals (PRI ALC, DRD, EW, LH, PH, PRI, RLW, TH, THT and VL) and found compliance with the timeliness of the assessments in all cases. Regarding the content of the assessments, the main deficiencies continue to be lack of documentation of follow-up when individuals refuse genital/rectal examination (PH) and deferral of the rectal examination without reason (LH). **Compliance:** Partial. **Current recommendations:** 1. Finalize the DMH standardized tool regarding this requirement. 2. Monitor this requirement based on at least a 20% sample using the standardized tool. This monitoring must address follow-up regarding incomplete items on the examination.
D.1.c.i.1	a review of systems;	99%
D.1.c.i.2	medical history;	99%
D.1.c.i.3	physical examination;	99%
D.1.c.i.4	diagnostic impressions; and	97%
D.1.c.i.5	management of acute medical conditions	99%

D.1.c.ii	within 24 hours of an individual's admission to each State hospital, the individual receives an Admission Psychiatric Assessment that includes:	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Ensure facility-wide implementation of the Initial Admission Psychiatric Assessments. **Findings:** ASH has implemented this recommendation. As mentioned earlier, the DMH has finalized a standardized monitoring tool regarding this requirement. **Recommendations 2 and 3, October 2007:** • Monitor the Initial Admission Psychiatric Assessments relative to EP requirements in D.1.c.ii.1 through D.1.c.ii.6. • Correct the deficiencies outlined by this monitor above. **Findings:** ASH used the DMH Admission Psychiatric Assessment Audit Form to assess compliance (December 2007 to February 2008). The average sample was 30% of admissions (Program IV) and the mean compliance rate for this requirement was 100%. The rates for EP requirements in D.1.c.ii.1 through D.1.c.ii.6 are listed in each corresponding cell below. To address low compliance in items D.1.c.ii.1, D.1.ii.c.3 and D.1.ii.c.6, the facility reported a corrective action plan including feedback by senior psychiatrists and implementation of the Psychiatric Quality Profile. **Other findings:** This monitor reviewed the charts of 11 individuals (ALC, CEG, DRD, EW, LH, PH, PRI, RLW, TH, THT and VL). Overall, the reviews found continued improvement the quality of the assessments, particularly in the charts selected from Program IV. However, the following deficiencies were noted:

		1. The history of present illness did not contain basic information that was needed to inform the assessment (EW). 2. The cognitive examination was not completed and no reason for this omission was documented other than limited time (PRI). 3. Examination of memory was not documented despite a provisional diagnosis to rule out cognitive impairment (EW) 4. The strengths formulation was limited to a generic list of some characteristics, such as young age (RLW), physical health (VL), verbalization and ambulation (PH) and/or a generic statement regarding willingness to participate in treatment that was repeated for most individuals (e.g. THT, TH, LH and ALC). 5. The results of the MMSE did not match a diagnosis of Mental Retardation that was listed on the corresponding WRP (GEG). 6. The risk assessment in most charts included a generic section on "demographics" that was not tailored to the clinical situation. 7. The assessment of insight and judgment was generic in most charts. 8. The plan of care (management of identified risks) ignored the risks of continued treatment with a high-risk medication given the individual's documented metabolic status (VL). These deficiencies must be corrected to achieve substantial compliance. **Compliance:** Partial. **Current recommendations**: 1. Finalize and implement a risk assessment tool during the first 24 hours of admission that aligns with the instructions regarding risk factors in the DMH format of the integrated psychiatric assessment. 2. Monitor the Admission Psychiatric Assessment, based on at least a 20% sample using the DMH standardized instrument.

		3. Provide data analysis that evaluates and delineates areas of low compliance and relative improvement (during the reporting period and compared with the last period).
D.1.c.ii.1	psychiatric history, including a review of presenting symptoms;	61%
D.1.c.ii.2	complete mental status examination;	94%
D.1.c.ii.3	admission diagnoses;	68%
D.1.c.ii.4	completed AIMS;	95%
D.1.c.ii.5	laboratory tests ordered; and	98%
D.1.c.ii.6	consultations ordered.	53%
	plan of care	85%
D.1.c.iii	within 7 days (60/72 hrs) of an individual's admission to each State hospital, the individual receives an Integrated Psychiatric Assessment that includes:	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Ensure facility-wide implementation of the Integrated Psychiatric Assessments. **Findings:** ASH has yet to implement this recommendation. The facility has implemented the Integrated Psychiatric Assessment in Program IV and plans to begin implementation in Program V on May 1, 2008. **Recommendation 2, October 2007:** Monitor the Integrated Psychiatric Assessments relevant to EP requirements in D.1.c.iii.1 through D.1.c.ii.10.

		Findings: ASH initiated monitoring during this review period. The facility presented data based on the DMH Integrated Assessment Psychiatric Audit Form (January and February 2008). The average sample was 76% of integrated assessments due in Program IV and the mean compliance rate for this requirement was 84%. The data regarding D.1.c.iii.1 through D.1.c.iii.10 are presented in each corresponding cell below. **Other findings:** This monitor reviewed a hospital-wide sample of 15 charts (ALC, BO, CC, CEG, DRD, EW, LB, LH, PH, PRI, RLW, TH, THT, VL and ZDS). The integrated assessments reviewed showed the following deficiencies: 1. In general, the integrated assessments were copies of the admission assessments, with occasional additional entries of information regarding events during the interval between the two assessments. This information was entered in the integrated assessments in areas that did not have a clinical rationale and that violated the flow of the assessments. 2. Too many charts included markings and corrections in the assessments without accompanying signatures to validate the entries. 3. The integrated assessments were missing in too many charts (EW, LH, PH, PRI, THT and VL) and delayed in some (RLW). 4. The deficiencies that were listed in D.1.c.ii were repeated in the integrated assessments. These deficiencies require immediate corrective actions. **Compliance:** Partial.

		Current recommendations: 1. Ensure facility-wide implementation of the Integrated Psychiatric Assessments. 2. Ensure that the format and content of the Integrated Psychiatric Assessment adequately integrates information that becomes available during the first seven days of hospitalization and that markings/entries in the assessments that violate the integrity of the records are not permitted. 3. Monitor the Integrated Psychiatric Assessment, based on at least a 20% sample using the DMH standardized instrument. 4. Provide data analysis that evaluates and delineates areas of low compliance and relative improvement (during the reporting period and compared with the last period).
D.1.c.iii.1	psychiatric history, including a review of present and past history;	32%
D.1.c.iii.2	psychosocial history;	92%
D.1.c.iii.3	mental status examination;	84%
D.1.c.iii.4	strengths;	96%
D.1.c.iii.5	psychiatric risk factors;	24%
D.1.c.iii.6	diagnostic formulation;	21%
D.1.c.iii.7	differential diagnosis;	82%
D.1.c.iii.8	current psychiatric diagnoses;	84%
D.1.c.iii.	psychopharmacology treatment plan; and	4% (facility did not present data related to sub-criteria)

9		
D.1.c.iii.10	management of identified risks.	88%
D.1.d	Each State hospital shall ensure that:	Please see sub-cells for compliance findings.
D.1.d.i	Clinically justifiable diagnoses are provided for each individual, and all diagnoses that cannot be clinically justified for an individual are discontinued no later than the next review;	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Provide continuing medical education to psychiatry staff to improve competency in the assessment of cognitive and other neuropsychiatric disorders. Ensure that the programs are relevant to the recommendation, and provide data regarding the professionals who have received training. **Findings:** Since the last review, the facility has provided the following CME programs: 1. A six-hour diagnosis/DSM-IV-TR training by Allen Frances, MD, the Chairperson of the Task Force on DSM-IV (February 22, 2008). 2. Journal Club: first Thursday of every month, 11:30 AM to 1:00 PM. 3. Clinical Case Conference: second Thursday of every month, 11:00 AM to noon. 4. Neuropsychology Seminar: every Tuesday, 8:30 AM to 9:30 AM. 5. Psychopharmacology Seminar: second Thursday every month, 10:30 AM to noon **Recommendation 2, October 2007:** Ensure that monitoring tool instructions address requirements for diagnostic formulation, differential diagnosis and updates of diagnosis, particularly those listed as NOS, as appropriate.

Findings:
The DMH Integrated Assessment Audit Form and Instructions are aligned with this recommendation.

Recommendation 3, October 2007:
Monitor this requirement, based on at least a 20% sample and analyze and correct factors related to low compliance.

Findings:
Same as in D.1.a.

Other findings:
This monitor reviewed the charts of 12 individuals who have received diagnoses listed as NOS continuously for more than two months during this reporting period. The review found a pattern of deficiencies in the documentation of efforts to finalize the diagnosis, as indicated; the individuals' status regarding cognitive impairments, as indicated; and/or alignment of the diagnostic information in the current WRP with the most recent psychiatric progress notes The following table outlines the charts reviewed:

Initials	Diagnosis
AE	Cognitive Disorder, NOS (no MMSE as indicated)
BO	Dementia NOS
CP	Dementia and Psychotic Disorder NOS
GP	Psychotic Disorder NOS
GRL	Mood Disorder, NOS (adequate justification on the revised diagnosis form)
JT	Mood Disorder NOS and Psychotic Disorder NOS
MAC	Psychotic Disorder NOS
MEW	Cognitive Disorder, NOS
REO	Psychotic Disorder NOS
RS-2	Cognitive Disorder, NOS, Depressive Disorder NOS

		<table><tr><td>SR</td><td>Dementia NOS and Psychotic Disorder NOS</td></tr><tr><td>TBR</td><td>Cognitive Disorder, NOS, Borderline Intellectual Functioning and Psychotic Disorder NOS</td></tr></table> **Compliance:** Partial. **Current recommendation**: Provide continuing medical education to psychiatry staff to improve competency in the assessment of cognitive and other neuropsychiatric disorders. Ensure that the programs are relevant to the recommendation, and provide data regarding the professionals who have received training.
D.1.d.ii	The documented justification of the diagnoses is in accord with the criteria contained in the most current DSM (as per DSM-IV-TR Checklist);	**Current findings on previous recommendation:** **Recommendation, October 2007:** Same as in D.1.a and D.1.i. **Findings:** Same as in D.1.a and D.1.i. **Compliance:** Partial. **Current recommendations**: Same as in D.1.a and D.1.i.
D.1.d.iii	Differential diagnoses, "deferred," or "rule-out" diagnoses, and diagnoses listed as "NOS" ("Not Otherwise Specified") are timely addressed (i.e., within 60 days), through clinically appropriate assessments, and	**Current findings on previous recommendation:** **Recommendation, October 2007:** Same as D.1.d.i.

	resolved in a clinically justifiable manner; and	**Findings:** Same as D.1.d.i. **Compliance:** Partial. **Current recommendations**: Same as D.1.d.i.
D.1.d.iv	"no diagnosis" is clinically justified and documented.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Same as above. **Findings:** ASH reported that the Chief of Psychiatry has reviewed all individuals currently hospitalized who are identified as having no diagnosis on Axis I. The one individual identified had clinical justification for no diagnosis. **Other findings:** This monitor reviewed the chart of the above-mentioned individual (MTF) and concurred with the Medical Director's assessment. **Compliance:** Substantial. **Current recommendation**: Same as in D.1.d.i.
D.1.e	Each State hospital shall ensure that psychiatric reassessments are conducted at a frequency that reflects the individual's clinical needs. At a	**Current findings on previous recommendation:**

	minimum the reassessments are completed weekly for the first 60 days on the admissions units and monthly on other units.	**Recommendation, October 2007:** Monitor this requirement based on at least a 20% sample and analyze and correct factors related to low compliance. **Findings:** Since the last review, ASH has implemented monitoring of the weekly and monthly Physician Progress Notes (PPNs). The facility presented data based on the DMH Weekly PPN Audit Form (February 2008) and the DMH Monthly PPN Audit Form (January and February 2008). The sample size was 59% of individuals who have been hospitalized between seven and 60 days for the weekly notes (Program IV). The average sample size for the monthly notes was 6% of individuals who have been hospitalized for 90 or more days (Program IV). The compliance rate for the weekly notes was 97%. The average compliance rate for the monthly notes was 100%. The facility has initiated monitoring of monthly notes facility-wide (March 1, 2008) **Other findings:** This monitor reviewed the charts of 10 individuals (ALC, DRD, EW, LH, PH, PRI, RLW, TH, THT and VL) to assess compliance with the frequency of weekly notes during the first 60 days of admission. The charts were selected from Program IV (ALC, EW, LH, RLW, THT and TH) and other programs (DRD, PH, PRI and VL). The review found compliance in five of these charts (ALC, EW, LH, PRI and TH). The notes had an adequate SOAP format (Subjective, Objective, Assessment/Diagnosis and Plan) and the content was generally adequate. This represents an improvement compared to the last review period. **Compliance:** Partial.

		Current recommendations: 1. Monitor this requirement based on a review of at least a 20% sample. 2. Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period).
D.1.f	Each State hospital shall ensure that psychiatric reassessments are documented in progress notes that address the following:	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Implement the new format of psychiatric reassessments facility-wide and ensure correction of the deficiencies outlined in this monitor's report and in the previous report. **Findings:** ASH has implemented this format in Program IV and has yet to achieve facility-wide implementation. See this monitor's findings below regarding implementation of this format. **Recommendations 2 and 3, October 2007:** • When the individuals receive both pharmacological and behavioral interventions, the reassessments need to address the following specific items: o Review of behavioral plans prior to implementation as documented in progress notes and/or behavioral plans; o Review of individual's progress in behavioral treatment; o Differentiation, as clinically appropriate, of learned behaviors from behaviors that are targeted for pharmacological treatment; and o Modification, as clinically appropriate, of diagnosis and/or pharmacological treatment based on above reviews/assessments. • Monitor this requirement based on at least a 20% sample.

		Findings: ASH used the DMH Monthly Progress Notes Audit Form to assess compliance (January and February 2008). As mentioned earlier, the average sample was 6% of the individuals who have been hospitalized for 90 days or more days in Program IV. The data (D.1.F.i to D.1.f.vii) are presented in each corresponding cell below. The facility did not provide analysis of these data. However, the data indicated improvement in all items, except for D.1.f.ii, compared to the last review period. This conclusion is limited by the fact that the data presented during the last review were not based on the new DMH standardized operational instructions that were used in this review. **Other findings:** Chart reviews by this monitor found the following pattern: 1. Progress was noted in the charts that were selected mostly from Program IV (AJ, CDB, CV, GEH, IZ, JDI, JK, JKC and LB). In these charts, there was evidence that the facility's implementation of the new format of the monthly progress notes has improved data gathering and presentation. However, the review also found that some items were redundant and/or duplicated and that critical components of the reassessments (e.g. interval history and benefits and risks of current treatment) were not properly individualized and resulted in generic reviews without direct relevance to the current status of the individuals. This monitor discussed the findings during a personal interview with the Chief of Psychiatry. 2. Some charts that were selected mostly from other programs (AA, EF, JT, MEB, MEW, MJC, SMB, TBR, TLW and WDB) contained documentation that did not comply with the facility's new format. In general, these notes failed to include most of the information specified in sub-sections of this requirement of the EP. 3. In general, the notes did not document the individual's progress in

		treatment when the WRP indicated that the psychiatrist was providing this intervention. This monitor also reviewed the charts of six individuals who have experienced the use of seclusion and/or restraints during this review period (AD, AJ, JLF, MJC, MR and RSP). The purpose of this review was to assess the documentation in the progress notes regarding the use of PRN/Stat medications prior to seclusion and/or restraints. This review is also relevant to the requirement in D.1.f.vi. The review showed that only one chart (RSP) contained evidence of appropriate use and documentation of this use. In general, the main deficiencies were as follows: 1. Use of PRN medications for generic indications; 2. Lack of documentation in the progress notes of the appropriateness and efficacy of the PRN regimen and of timely adjustment of regular treatment following the repeated use of PRN medications; and 3. Lack of documentation of a face-to-face assessment by the psychiatrist within 24 hours of the administration of Stat medications. **Compliance:** Partial. **Current recommendations:** 1. Ensure implementation of the new format of monthly progress notes facility-wide and revise the format to address this monitor's findings above. 2. Monitor this requirement based on a review of at least a 20% sample. 3. Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and

		compared to the last period). 4. Monitor documentation of the scope and goals of individual psychotherapy and of the individual's progress in treatment when the WRP indicates that the psychiatrist is providing this intervention.
D.1.f.i	significant developments in the individual's clinical status and of appropriate psychiatric follow up;	29%
D.1.f.ii	Timely and justifiable updates of diagnosis and treatment, as clinically appropriate;	20%
D.1.f.iii	Analyses of risks and benefits of chosen treatment interventions;	40%
D.1.f.iv	Assessment of, and attention to, high-risk behaviors (e.g., assaults, self-harm, falls) including appropriate and timely monitoring of individuals and interventions to reduce risks;	23%
D.1.f.v	Responses to and side effects of prescribed medications, with particular attention to risks associated with the use of benzodiazepines, anticholinergic medications, polypharmacy (use of multiple drugs to address the same condition), and conventional and atypical antipsychotic medications;	35%
D.1.f.vi	Timely review of the use of "pro re nata" or "as-needed" ("PRN") and "Stat" (i.e., emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such	21%

	use; and	
D.1.f.vii	Verification in a clinically justifiable manner, that psychiatric and behavioral treatments are properly integrated. The psychiatrist shall review the positive behavior support plan prior to implementation to ensure consistency with psychiatric formulation, document evidence of regular exchange of data or information with psychologists regarding differentiation of learned behaviors and behaviors targeted for psychopharmacological treatments, and document evidence of integration of treatments.	3%
D.1.g	When individuals are transferred between treatment teams, a psychiatric transfer note shall be completed addressing: review of medical and psychiatric course of hospitalization, including medication trials; current target symptoms; psychiatric risk assessment; current barriers to discharge; and anticipated benefits of transfer.	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Provide ongoing feedback and mentoring by senior psychiatrists to ensure that the transfer psychiatric assessments correct the deficiencies outlined by this monitor. **Findings:** ASH did not address this recommendation. **Recommendation 2, October 2007:** Monitor this requirement based on a review of at least a 20% sample. **Findings:** ASH used the DMH Physician Inter Unit Transfer Note Audit Form to assess compliance (February 2008). The sample was 18% of inter-unit transfers. The indicators and corresponding compliance rates are outlined in the following table:

1.	*Psychiatric course of hospitalization including medication trials*	30%
2.	*Medical course of hospitalization*	17%
3.	*Current target symptoms*	55%
4.	*The note meets conditions for Psychiatric Risk assessment*	32%
5.	*Barriers to discharge, as related to the discharge criteria in the WRP*	11%
6.	*Anticipated benefits of transfer*	45%

The facility did not provide analysis of the data. However, compared to the last review period, there was a pattern of improvement in all similar items. This pattern is limited by the fact that the data presented during the last review were not based on the new DMH standardized operational instructions that were used in this review

Recommendation 3, October 2007:
Ensure that individuals who present severe management problems and require frequent inter-unit transfers receive PBS plans that are adequately designed and implemented prior to transfers.

Findings:
Since the last review, ASH has initiated a process of review by the Enhanced Trigger Review Committee of individuals with severe management problems. This process includes a review to ensure that PBS was instituted in an adequate and timely manner prior to inter-unit transfers.

Other findings:
This monitor reviewed the charts of six individuals (ALC, CP, DRD, LH, THT and WST) who experienced inter-unit transfers during this review period. The following table outlines this review:

Initials	Date of transfer
ALC	03/03/08
CP	04/14/08
DRD	02/25/08
LH	03/13/08
THT	03/11/08
WST	04/08/08

The reviewed found that facility has implemented a format for these assessments that aligned with this requirement. The assessments were documented in all cases except one (DRD). In general, the assessments included adequate delineation of current target symptoms, diagnosis and medications. However, there was a pattern of inconsistent and generally inadequate review of course of hospitalization (psychiatric and medical), anticipated benefits of transfer and discharge barriers.

Compliance:
Partial.

Current recommendations:
1. Provide ongoing feedback and mentoring by senior psychiatrists to ensure that the transfer psychiatric assessments correct the deficiencies outlined by this monitor.
2. Monitor this requirement based on a review of at least a 20% sample.
3. Provide data analysis that evaluates low compliance and delineates areas of relative improvement (during the reporting period and compared to the last period).
4. Provide information regarding the frequency of inter-unit transfers of individuals who present severe management problems and have not received behavioral interventions in accord with PBS principles.

2. Psychological Assessments		
		Methodology: <u>Interviewed</u>: 1. Individuals TF and JC 2. Charles Broderick, PhD, Senior Psychologist 3. Charlie Joslin, Clinical Administrator 4. Chris McDonald, PsyD, Admissions Psychologist 5. Christine Mathiesen, PsyD, Director C-PAS 6. Cindy Duke, PhD, Neuropsychologist 7. Dante Karas, Assistant Mall Director 8. Diane Imrem, PsyD, Chief of Psychology 9. Diane Walker, PhD, Psychologist, PBS Team Member 10. Don Johnson, PhD, Psychologist 11. Donna Nelson, Standards Compliance Director 12. Glen Potts, PhD, Psychologist, PBS Team Member 13. Henry Ahlstrom, PhD, Psychologist 14. Jeffrey Teuber, PhD, Senior Psychologist, PBS Team Leader 15. Joe DeBruin, PhD, Psychologist, Chair C-PAS 16. John De Morales, Executive Director 17. Leslie Bolin, PhD, Neuropsychologist 18. Louis Santiago, SPT, BY CHOICE Coordinator. 19. Matt Hennessy, PhD, Psychologist, Mall Director 20. Michael Tandy, PhD, Psychologist 21. Rich Morey, PhD, Senior Psychologist 22. Theresa George, PhD, PBS Supervisor <u>Reviewed</u>: 1. Charts of the following 46 individuals: ADG, AM, AOA, AR, AS, BB, BS, CC, CCO, DB, DE, DL, DNM, DS, EI, FE, FGG, FJE, FN, GCM, GEP, GS, GV, HC, IS, JCA, JF, JG, KEL, KH, LC, LSS, MF, MG, MM, MS, OAO, RA, RB, RBD, RH, SA, SB, SJ, SNA, and WM

		2. ASH Diagnosis Audit (February 2008) 3. BY CHOICE Monthly Fidelity Checks 4. CA DMH Key Indicators: Triggers and Physical Health Indicators 5. Cognitive Disorders Diagnosed After Admission, last six months 6. DCAT Behavior Guidelines Fidelity Checklists 7. DMH Integrated Assessment: Psychology Section 8. DMH Integrated Assessment: Rehabilitation Therapy Section. 9. DMH Integrated Assessment: Social Work Section 10. DMH Psychology Manual Training 11. Interview/Psychological Testing Observation Form 12. List of ASH Diagnoses Audit (February 2008) 13. List of individuals referred for neuropsychological assessments 14. List of school-age and other individuals needing cognitive and academic assessments within 30 Days of Admission 15. List showing the number of individuals age 23 and under 16. PBS Team Monitoring Forms 17. Reynolds Intellectual Screening Test (RIST) Competency Training 18. RIST Staff Competency Evaluations 19. Test Observation Logs <u>Observed</u>: 1. WRPC for CM, Program III, Unit 21 2. WRPC for MG, Program IV, Unit 9A
D.2.a	Each State hospital shall develop and implement standard psychological assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum, diagnostic neuropsychological assessments, cognitive assessments, and I.Q./achievement assessments, to guide psychoeducational (e.g., instruction regarding the illness or disorder, and the purpose or objectives	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Ensure that revised documents, where applicable, align across DMH hospitals. **Findings:** According to Charles Broderick, Senior Supervising Psychologist in charge of the Psychology Assessments, ASH has implemented the

	of treatments for the same, including medications), educational, rehabilitation, and habilitation interventions, and behavioral assessments (including functional assessment of behavior in schools and other settings), and personality assessments, to inform positive behavior support plans and psychiatric diagnoses.	Statewide Psychology manual. In addition, the Statewide Psychology Committee is said to have drafted the PBS, BY-CHOICE, and DCAT Manuals. Currently, only the PBS Manual has gained approval. **Recommendation 2, October 2007:** Finalize and implement all applicable documents that codify the requirements of the EP. **Findings:** According to Diane Imrem, Chief of Psychology, the Psychology Department made the necessary changes to the documents that codify EP requirements. The documents are also aligned with the Psychology Rules and Regulations and the Medical Staff By-Laws. The modified documents have the approval of the Medical Executive Committee. This monitor's findings from review of the relevant documents (IAPs, Psychology Manual, and PBS Manual) were in agreement with the facility's report. **Recommendation 3, October 2007:** Conduct competency-based training for all psychologists to the new clinical information included in the revised documents. **Findings:** This monitor reviewed ASH's training documentation, which showed that training for psychologists was conducted on September 6 and 12 and October 2, 2007. **Compliance:** Substantial. **Current recommendation**: Finalize and get the necessary approvals for the BY CHOICE, and DCAT manuals.

<table>
<tr>
<td>D.2.b</td>
<td>Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals, as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.</td>
<td>
Current findings on previous recommendation:

Recommendation 1, October 2007:
Ensure that all individuals admitted to the facility have their academic and cognitive assessments conducted within 30 days unless comparable testing has been performed within one year of admission and is available for review by the interdisciplinary team.

Findings:
ASH used item #1 from the DMH Psychology Assessment monitoring form (see below) to address this requirement, reporting 21% compliance. The table below with its monitoring indicator showing the number of admissions each month (N), the number of charts audited each month (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

Each State hospital shall require the completion of cognitive and academic assessments within 30 days of admission of all school-age and other individuals, as required by law, unless comparable testing has been performed within one year of admission and is available to the interdisciplinary team.

<table>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean</td></tr>
<tr><td>N</td><td>10</td><td>1</td><td>6</td><td>5</td><td>3</td><td>3</td><td></td></tr>
<tr><td>n</td><td>10</td><td>1</td><td>6</td><td>5</td><td>3</td><td>3</td><td></td></tr>
<tr><td>%S</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td></td></tr>
<tr><td>%C #1</td><td>10</td><td>0</td><td>0</td><td>20</td><td>66</td><td>66</td><td>21</td></tr>
</table>

This monitor reviewed seven charts of individuals under 23 years of age (ADG, FE, FJE, FN, KEL, SB and WM). Three of these individuals (FE, FJE and SB) did not require any cognitive and/or academic assessments as they possessed a GED or a high school diploma. Assessments were completed for WM, but were untimely. Assessments
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		have yet to be completed for the remaining three individuals' (ADG, FN and KEL). **Recommendations 2 and 3, October 2007:** • Develop and maintain an accurate count of individuals eligible to have their cognitive and academic assessments conducted within 30 days. • Develop and implement monitoring and tracking instruments to assess this requirement. **Findings:** According to the Senior Supervising Psychologist, he uses the HIMD data to inform unit psychologists of individuals under 23 years of age admitted in the facility. The unit psychologists then are to review the individuals' records to ascertain if the individuals require academic and cognitive assessments. **Recommendation 4, October 2007:** Ensure that individuals who could not be tested within the first 30 days of admission, for medical or other reasons, are documented and followed up to make sure that such evaluations are completed when the individual is ready for assessment. **Findings:** This monitor's documentation review (list of individuals under 23 years of age) found that ASH had 139 individuals below 23 years of over the last six months (September 2007 through February 2008). Cognitive and academic assessments had been completed on only one of the 139 individuals. According to the Senior Supervising Psychologist, ASH did not have a sufficient number of psychologists to fulfill this requirement. There are a number of admission units without psychologists.

<table>
<tr><td></td><td></td><td>Compliance:
Partial.

Current recommendations:
1. Ensure that all individuals admitted to the facility have their academic and cognitive assessments conducted within 30 days unless comparable testing has been performed within one year of admission and is available for review by the interdisciplinary team.
2. Ensure that individuals who could not be tested within the first 30 days of admission, for medical or other reasons, are documented and followed up to make sure that such evaluations are completed when the individual is ready for assessment.</td></tr>
<tr><td>D.2.c</td><td>Each State hospital shall ensure that all clinicians responsible for performing or reviewing psychological assessments and evaluations are verifiably competent in the methodology required to conduct the assessment.</td><td>Current findings on previous recommendation:

Recommendation 1, October 2007:
Ensure that all psychologist positions are filled.

Findings:
ASH continues to experience severe shortage of Psychology staff. This monitor's documentation review (staffing list and staffing patterns) found that nine units operate without a psychological service provider. The tables below show the pattern of staff shortage per month for each category (WRP Psychologists, Senior Psychologist Mentors, and Senior Psychologists for Specialty Services) from September 2007 to February 2008. According to Charles Broderick, the "needed" staffing strength was calculated on ASH's full capacity of 1258 beds.

WRP Psychologists Staffing:

<table>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean</td></tr>
<tr><td>Needed</td><td>94</td><td>94</td><td>94</td><td>94</td><td>94</td><td>94</td><td></td></tr>
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</table>

Positions Filled	17	17	17	18	18	22	
% Vacancy	82	82	82	81	81	76	81

Senior Psychologists (Mentors) Staffing:

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
Needed	16	16	16	16	16	16	
Positions Filled	4	4	4	4	4	4	
% Vacancy	75	75	75	75	75	75	75

Senior Psychologists (Specialty Services) Staffing:

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
Needed	23	23	23	23	23	23	
Positions Filled	4	4	4	4	5	5	
% Vacancy	83	83	83	83	78	78	81

Recommendation 2-3, October 2007:

- Ensure that senior psychologists have the necessary administrative support in their clinical authority of teaching, training and evaluating other psychology staff.
- Ensure that senior psychologists have the necessary time to properly mentor and supervise other psychology staff.

Findings:

This monitor's interview with the Chief of Psychology found that the Psychology Department has three Senior Supervisory Psychologists. According to the Senior Supervising Psychologists, they receive administrative support in their clinical authority of teaching, training

		and evaluating other psychology staff. However, per the Chief of Psychology, the three Senior Supervising Psychologists are unable to perform all required tasks and in a timely manner (mentoring psychologists, monitoring quality of assessments/services, conducting training/teaching, programming, and conducting EP-related tasks). **Compliance:** Partial. **Current recommendation**: Ensure that all psychologist positions are filled.
D.2.d	Each State hospital shall ensure that all psychological assessments, consistent with generally accepted professional standards of care, shall:	**Compliance:** Partial.
D.2.d.i	expressly state the clinical question(s) for the assessment;	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Ensure that the statements of the reasons for referral are concise and clear. **Findings:** ASH audited 47 Focused Psychological Assessments using item #3 from the DMH Psychology Assessment monitoring form to address this requirement, reporting 81% compliance. This monitor reviewed ten Focused Psychology Assessments (AS, BB, CC, CCO, DL, DS, GEP, JG, MG and RH). Seven of them (AS, BB, DL, GEP, JG, MG and RH) addressed the clinical question in a concise and clear manner. The remaining three assessments (CC, CCO, and DS) failed to be concise when stating the clinical question.

		Recommendation 2 and 3, October 2007: • Ensure that there is continuity among the various sections that connect referral questions to conclusions to appropriate recommendations and therapies available within ASH. • Ensure that all psychological assessments meet at least generally acceptable professional standards. **Findings:** This monitor reviewed ten charts (AS, BB, CC, CCO, DL, DS, GEP, JG, MG and RH). Nine of the Focused Psychology Assessments in the charts (BB, CC, CCO, DL, DS, GEP, JG, MG and RH) showed continuity among the various sections, from clinical questions to conclusions and recommendations. One of them (AS) did not show a good linkage among the sections. **Current recommendations**: 1. Ensure that the statements of the reasons for referral are concise and clear. 2. Ensure that there is continuity among the various sections that connect referral questions to conclusions to appropriate recommendations and therapies available within ASH.
D.2.d.ii	include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations;	**Current findings on previous recommendation:** **Recommendation, October 2007:** Ensure that all psychological assessments include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations. **Findings:** ASH audited 47 Focused Psychological Assessments using item #4 from the DMH Psychology Assessment monitoring form to address this

		requirement, reporting 79% compliance. This monitor reviewed ten charts (AS, BB, CC, CCO, DL, DS, GEP, JG, MG and RH). Eight of the Focused Psychological Assessments in the charts (BB, CCO, DL, DS, GEP, JG, MG and RH) addressed the clinical question and the findings included sufficient information to inform the psychiatric diagnosis, identified the individual's treatment and rehabilitation needs, and suggested interventions for inclusion in the individual's WRP. Two Focused Psychological Assessments (AS and CC) did not satisfy the required elements. **Current recommendation**: Ensure that all psychological assessments include findings specifically addressing the clinical question(s), but not limited to diagnoses and treatment recommendations.
D.2.d.iii	Specify whether the individual would benefit from individual therapy or group therapy in addition to attendance at mall groups;	**Current findings on previous recommendation:** **Recommendation, October 2007:** Ensure that all psychological assessments specify whether the individual would benefit from individual therapy or group therapy. **Findings:** ASH audited 47 Focused Psychological Assessments using item #5 from the DMH Psychology Assessment monitoring form to address this requirement, reporting 53% compliance. This monitor reviewed ten charts (AS, BB, CC, CCO, DL, DS, GEP, JG, MG and RH). Eight of the Focused Psychological Assessments in the charts (BB, CCO, DL, DS, GEP, JG, MG and RH) indicated if the individual would benefit from individual and/or group therapy, and two of them (AS and CC) did not.

		Current recommendation: Ensure that all psychological assessments specify whether the individual would benefit from individual therapy or group therapy.
D.2.d.iv	be based on current, accurate, and complete data;	**Current findings on previous recommendation:** **Recommendation, October 2007:** Ensure that all psychological assessments are based on current, accurate, and complete data. **Findings:** ASH audited 47 Focused Psychological Assessments using item #6 from the DMH Psychology Assessment monitoring form to address this requirement, reporting 81% compliance. This monitor reviewed ten charts (AS, BB, CC, CCO, DL, DS, GEP, JG, MG and RH). Five of the Focused Psychological Assessments in the charts (BB, CCO, DS, GEP and MG) included all identification information, listed the sources of information, and documented direct observation information, including the individual's cooperation and motivation during the evaluation. The remaining five assessments (AS, CC, DL, JG and RH) did not include all of the necessary information. **Current recommendation**: Ensure that all psychological assessments are based on current, accurate, and complete data.
D.2.d.v	determine whether behavioral supports or interventions (e.g., behavior guidelines or mini behavior plans) are warranted or whether a full positive behavior support plan is required;	**Current findings on previous recommendation:** **Recommendation, October 2007:** Ensure that all psychological assessments of individuals with maladaptive behavior meet this requirement.

		Findings: ASH audited 47 Focused Psychological Assessments using item #7 from the DMH Psychology Assessment monitoring form to address this requirement, reporting 34% compliance. This monitor reviewed ten charts (AS, BB, CC, CCO, DL, DS, GEP, JG, MG and RH). Eight of the Focused Psychological Assessments in the charts (AS, CCO, DL, DS, GEP, JG, MG and RH) had indicated whether the individual would benefit from behavioral guidelines or required Positive Behavioral Support. The remaining two assessments (BB and CC) did not include all the relevant information. **Current recommendation**: Ensure that all psychological assessments of individuals with maladaptive behavior meet this requirement.
D.2.d.vi	include the implications of the findings for interventions;	**Current findings on previous recommendation:** **Recommendation, October 2007:** Ensure that all focused psychological assessments include the implications of the findings for interventions, especially psychosocial rehabilitation. **Findings:** ASH audited 47 Focused Psychological Assessments using item #8 from the DMH Psychology Assessment monitoring form to address this requirement, reporting 72% compliance. This monitor reviewed ten charts (AS, BB, CC, CCO, DL, DS, GEP, JG, MG and RH). Six of the Focused Psychological Assessments in the charts (BB, CCO, DL, DS, GEP and MG) contained documentation of the implications of the findings for PSR and other interventions, and four of them (AS, CC, JG and RH) did not.

		Current recommendation: Ensure that all focused psychological assessments include the implications of the findings for interventions, especially psychosocial rehabilitation.
D.2.d.vii	identify any unresolved issues encompassed by the assessment and, where appropriate, specify further observations, records review, interviews, or re-evaluations that should be performed or considered to resolve such issues; and	**Current findings on previous recommendation:** **Recommendation, October 2007:** Ensure that all focused psychological assessments meet this requirement. **Findings:** ASH audited 47 Focused Psychological Assessments using item #9 from the DMH Psychology Assessment monitoring form to address this requirement, reporting 32% compliance. This monitor reviewed ten charts (AS, BB, CC, CCO, DL, DS, GEP, JG, MG and RH). Four of the Focused Psychological Assessments (DS, GEP, MG and RH) contained statements on unresolved issues encompassed by the assessment, and avenues to resolve the inconsistencies and a timeline for doing so were provided. The remaining six (AS, BB, CC, CCO, DL and JG) did not address inconsistencies and/or provide the steps and timelines to resolve them. **Current recommendation**: Ensure that all focused psychological assessments meet this requirement.
D.2.d.viii	Use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines	**Current findings on previous recommendations:** **Recommendations 1 and 2, October 2007:** • Ensure that all psychologist use assessment tools and techniques

	for testing.	appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing. • Ensure that the American Psychological Association Ethical Standards and Guidelines for Testing are followed. **Findings:** ASH audited 47 Focused Psychological Assessments using item #10 from the DMH Psychology Assessment monitoring form to address this requirement, reporting 100% compliance. This monitor reviewed ten charts (AS, BB, CC, CCO, DL, DS, GEP, JG, MG and RH). Nine of the Focused Psychological Assessments in the charts (CC, JG, MG, AS, DS, DL, GEP, BB, and CC0) had used assessment tools appropriate for the individuals in accordance with the American Psychological Association Ethical Standards and Guidelines for Testing. The assessment tools used were included in the DMH Clinical Indicator list of approved instruments. The assessments also included statements of confidentiality. One of them (RH) did not include one or more of the required elements. This monitor was not privy to the administration of the instruments and scoring of the assessments to know if the assessments were conducted in accordance with the User manual for the instruments. However, this monitor's documentation review found that the Senior Supervising Psychologists had observed examiners during the interviews and test administrations. The data from the direct observations evidenced proper test administration procedures by the examiners. **Current recommendations:** 1. Ensure that all psychologists use assessment tools and techniques appropriate for the individuals assessed and in accordance with the American Psychological Association Ethical Standards and Guidelines for testing.

<table>
<tr><td></td><td></td><td>2. Ensure that the American Psychological Association Ethical Standards and Guidelines for Testing are followed.</td></tr>
<tr><td>D.2.e</td><td>Each State hospital shall ensure that all psychological assessments of all individuals residing at each State hospital who were admitted there before the Effective Date hereof shall be reviewed by qualified clinicians with demonstrated current competency in psychological testing and, as indicated, revised to meet the criteria in § [IV.B.1 and IV.B.2], above.</td><td>Current findings on previous recommendation:

Recommendations 1-3, October 2007:
• Maintain a list of clinicians with demonstrated current competency in psychological testing and identify any resource shortages or allocation issues.
• Develop a timeline (end date within the next 12 months) by which the psychological assessments of individuals admitted prior to June 1, 2006 will be reviewed.
• Monitor compliance with the prepared schedule to stay abreast of bottlenecks or obstacles to completion.

Findings:
ASH used item #11 from the DMH Psychology Assessment monitoring form (see below) to address this requirement, reporting 53% compliance. The table below with its monitoring indicator showing the number of individuals admitted prior to June 1, 2006 and still present in ASH per month (N), the number of Integrated Psychological Assessments audited each month (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

All psychological assessments of all individuals who were admitted before June 1, 2006 shall be reviewed by qualified clinicians with demonstrated current competency in psychological testing and, as indicated, revised to meet the criteria in § [IV.B.1 and IV.B.2], above.

<table>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean</td></tr>
<tr><td>N</td><td>604</td><td>561</td><td>539</td><td>506</td><td>475</td><td>439</td><td></td></tr>
<tr><td>N</td><td>4</td><td>4</td><td>5</td><td>12</td><td>106</td><td>69</td><td></td></tr>
<tr><td>%S</td><td>100</td><td>100</td><td>100</td><td>20</td><td>83</td><td>52</td><td></td></tr>
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<table>
<tr><td>%C #11</td><td>1</td><td>1</td><td>1</td><td>10</td><td>38</td><td>71</td><td>53</td></tr>
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However, this monitor's review of documentation and interview of the Senior Supervising Psychologist found that ASH has completed review/re-evaluation of the remaining 429 IAPs (as shown for the month of February, in the table above) as of March 3, 2008. A handful of individuals who were in court were yet to have their evaluations reviewed/re-administered. According to the Senior Supervising Psychologist, the Integrated Assessment Psychology Section will be reviewed/re-administered for these individuals if and when they return to the facility.

This monitor reviewed eight charts of individuals admitted to the facility prior to June 1, 2006 (CGO, CO, DE, PS, RD, RE, RLD and TD); all eight of the Integrated Assessments in the charts had been reviewed and where indicated the individual was re-evaluated. This monitor also reviewed the documentation of the training and qualification of the examiners conducting the review evaluations. The documentation showed that the examiners had the necessary education and training to conduct the evaluations.

Compliance:
Full.

Current recommendations:
Continue to conduct all Integrated Psychology Assessments in a timely manner.
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<td>D.2.f</td>
<td>Each State hospital shall ensure that all appropriate psychological assessments shall be provided in a timely manner whenever clinically indicated, consistent with generally accepted professional standards of care, including whenever</td>
<td>Compliance:
Partial.</td>
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<tr><td></td><td>there has been a significant change in condition, a lack of expected improvement resulting from treatment, or an individual's behavior poses a significant barrier to treatment, therapeutic programming, safety to self or others, or school programming, and, in particular:</td><td></td></tr>
<tr><td>D.2.f.i</td><td>before an individual's therapeutic and rehabilitation service plan is developed, a psychological assessment of the individual shall be performed that will:</td><td>Current findings on previous recommendation:

Recommendations 1 and 2, October 2007:
• Ensure that integrated psychological assessments are conducted in a timely manner as required.
• Ensure an adequate number of psychologists to provide timely psychological assessments of individuals.

Findings:
ASH used item #12 from the DMH Psychology Assessment monitoring form (Each State hospital shall ensure that all appropriate psychological assessments shall be provided in a timely manner) to address this requirement, reporting 18% compliance. The table below with its monitoring indicator showing the number of new Integrated Psychological Assessments (IAPs) due each month (N), the number of IAPs audited each month (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

<table>
<tr><td></td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean</td></tr>
<tr><td>N</td><td>109</td><td>121</td><td>94</td><td>108</td><td>92</td><td>91</td><td></td></tr>
<tr><td>N</td><td>109</td><td>121</td><td>94</td><td>108</td><td>92</td><td>91</td><td></td></tr>
<tr><td>%S</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td></td></tr>
<tr><td>%C #12</td><td>16</td><td>22</td><td>12</td><td>16</td><td>13</td><td>29</td><td>18</td></tr>
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According to the Senior Supervising Psychologist, ASH does not have the necessary number of psychologists to conduct all IAPs in a timely</td></tr>
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		manner, even with the facility's efforts to utilize quarter-time psychologists. Furthermore, three new admission units were opened in the past six months, making it even more difficult to complete assessments. In addition, a number of psychologists in the admission units were new hires requiring training and supervision and not up to speed in conducting the evaluations. This monitor reviewed ten charts (CC, DB, GV, HC, LC, MM, RA, RB, SA and SJ). Six of the IAPs in the charts (CC, DB, GV, HC, RA and SJ) were conducted in a timely manner. One of them (MM) was present but untimely, and the remaining three (LC, RB and SA) were not completed. **Current recommendations**: 1. Ensure that integrated psychological assessments are conducted in a timely manner as required. 2. Ensure an adequate number of psychologists to provide timely psychological assessments of individuals.
D.2.f.i.1	address the nature of the individual's impairments to inform the psychiatric diagnosis; and	**Current findings on previous recommendation:** **Recommendation, October 2007:** Ensure that integrated psychological assessments address the nature of the individual's impairments to inform the psychiatric diagnosis. **Findings:** ASH used item #13 from the DMH Psychology Assessment monitoring form (*Address the nature of the individual's impairments to inform the psychiatric diagnosis*) to address this requirement, reporting 28% compliance. The table below with its monitoring indicator showing the number of new Integrated Psychological Assessments (IAPs) due each month (N), the number of IAPs audited each month (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
N	109	121	94	108	92	91	
N	109	121	94	108	92	91	
%S	100	100	100	100	100	100	
%C #13	15	34	31	31	27	32	28

This monitor reviewed ten charts (CC, DB, GV, HC, LC, MM, RA, RB, SJ and SNA). Eight of the IAPs in the charts (CC, DB, GV, HC, LC, MM, RA and SJ) documented the nature of the individual's psychological impairments and provided adequate information to inform the psychiatric diagnosis. The remaining two (RB and SNA) did not document sufficient information.

Current recommendation:
Ensure that integrated psychological assessments address the nature of the individual's impairments to inform the psychiatric diagnosis.

D.2.f.i.2	provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process;	**Current findings on previous recommendation:** **Recommendations 1 and 2, October 2007:** • Ensure that all elements that would affect complete understanding of an individual's psychological functioning are considered when monitoring this item. • Ensure accurate evaluation of psychological functioning that informs WRPT's of individuals' rehabilitation service needs. **Findings:** ASH used item #14 from the DMH Psychology Assessment monitoring form (*Provide an accurate evaluation of the individual's psychological functioning to inform the therapeutic and rehabilitation service planning process*) to address this requirement, reporting 29% compliance. The table below with its monitoring indicator showing the

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<td>number of new Integrated Psychological Assessments (IAPs) due each month (N), the number of IAPs audited each month (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

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<tr><td>%C #14</td><td>5</td><td>34</td><td>29</td><td>39</td><td>34</td><td>34</td><td>29</td></tr>
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This monitor reviewed nine charts (DB, GV, HC, LC, MM, RA, RB, SJ and SNA). Three of the IAPs in the charts (HC, LC and SJ) provided an accurate and valid evaluation of the individual's psychological functioning, and the assessment data were interpreted and translated into practical terms to assist the WRPTs to determine the nature, direction, and sequence of interventions needed for the individual's rehabilitation. The remaining six (DB, GV, MM, RA, RB and SNA) failed to fulfill this criteria.

Current recommendations:
1. Ensure that all elements that would affect complete understanding of an individual's psychological functioning are considered when monitoring this item.
2. Ensure accurate evaluation of psychological functioning that informs WRPT's of individuals' rehabilitation service needs.</td>
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<td>D.2.f.ii</td>
<td>if behavioral interventions are indicated, a structural and functional assessment shall be performed, consistent with generally accepted professional standards of care, by a professional having demonstrated competency in positive behavior supports; and</td>
<td>Current findings on previous recommendation:

Recommendation 1, October 2007:
Ensure that Level of Care staff is familiar with criteria for referral to the PBS team when individuals have significant learned maladaptive behaviors that are not amenable to behavioral guidelines.</td>
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		Findings: This monitor's review of training documentation (monthly training of new employees, and other employees in the facility), interview of WRPT members and interview of the Senior Supervising Psychologists found that all Level of Care staff were made aware of the process for PBS referrals on individuals with learned maladaptive behaviors. **Recommendations 2-4, October 2007:** • Ensure that PBS referrals get timely attention to assist Level of Care staff in managing individuals with significant learned maladaptive behaviors. • Ensure appropriate structured and functional assessments are undertaken by a qualified psychologist when an individual has learned maladaptive behavior. • Ensure that referrals for intensive consultations are made to the BCC and not to the PCMC. **Findings:** ASH did not develop and implement any PBS protocols/interventions in the last six months and therefore there were no structural/functional assessments to be conducted. According to the Chief of Psychology, by policy and practice, all referrals come directly to the PBS teams through the PBS-BCC checklists; PCMC no longer has any role with regard to individuals with learned maladaptive behaviors. **Current recommendations**: 1. Ensure that PBS referrals get timely attention to assist Level of Care staff in managing individuals with significant learned maladaptive behaviors. 2. Ensure appropriate structured and functional assessments are undertaken by a qualified psychologist when an individual has learned maladaptive behavior.

D.2.f.iii	additional psychological assessments shall be performed, as appropriate, where clinical information is otherwise insufficient, and to address unresolved clinical or diagnostic questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis" and "NOS" diagnoses.	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Ensure that additional psychological assessments are performed, as appropriate, where clinical information is otherwise insufficient and address unresolved clinical or diagnostic questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis," and "NOS" diagnoses. **Findings:,** According to the Senior Supervising Psychologist, as of April 2008, ASH cared for 576 individuals with one or more diagnosis in the "uncertain" category (rule out, deferred, no diagnosis, and NOS). ASH audited charts of 25 individuals with these diagnostic uncertainties, using items #16 to #21 from the DMH Psychology Assessment monitoring form to address this requirement, reporting 0% mean compliance on all items. According to Charles Broderick, Senior Supervising Psychologist, the poor compliance was due to non-completion of the IAP. This monitor reviewed 13 charts (DB, DE, FJE, HC, JCA, JF, KH, LC, MF, MS, RA, RB and SJ) of individuals with diagnostic uncertainties. Two of the IAPs in the charts (FJE and MS) had requests for follow-up evaluations to clarify their diagnostic uncertainties. The IAPs in the remaining 11 charts (DB, DE, HC, JCA, JF, KH, LC, MF, RA, RB and SJ) did not contain a request for follow-up evaluations and timelines for conducting these evaluations, This monitor's documentation review (ASH Diagnosis Audit, February 2008) found that of the 923 charts ASH reviewed, 14% of individuals carried a "Deferred" diagnosis on Axis II; 5% carried a "Rule Out" diagnosis on Axis I, II, and/or III; and 49% carried a generalized diagnosis (e.g. NOS).

		The findings also revealed a pattern of deficits/errors. For example 6% of 1103 charts reviewed had a wrong diagnosis on Axis I and/or II (e.g. Mental Retardation on Axis I); 3% had multiple diagnoses for the same signs/symptoms or conflicting diagnoses; 19% had duplicate diagnosis (e.g. Psychotic Disorders NOS was entered twice on Axis I); 0.6% missed a major mental illness diagnosis on Axis I; 2% missed an Axis II diagnosis; 21% missed an Axis III diagnosis; 1% missed an Axis V diagnosis; and 2% missed a diagnosis on all five Axis. According to Donna Nelson, Director of Standards Compliance, many of these deficits/errors have been corrected since the audit. She has arranged for another audit in May 2008. **Recommendation 3, October 2007:** Ensure that ASH's monitoring system and the diagnoses in the individuals' assessments are congruent. **Findings:** This monitor's interview of Donna Nelson and documentation review (ASH Diagnosis Audit, February 2008) found that 1103 charts were audited. Conflicting diagnosis was observed between the ASH's monitoring system and the individuals' assessments in 15% of Axis I diagnosis, 9% of Axis II, and 12% of Axis III diagnosis. According to Donna Nelson, many of the errors and conflicts have since been corrected. She has planned for a follow-up audit in May 2008. **Current recommendation**: Ensure that additional psychological assessments are performed, as appropriate, where clinical information is otherwise insufficient and address unresolved clinical or diagnostic questions, including differential diagnosis, "rule-out," "deferred," "no-diagnosis," and "NOS" diagnoses.

D.2.g	For individuals whose primary language is not English, each State hospital shall endeavor to assess them in their own language; if this is not possible, each State hospital will develop and implement a plan to meet the individuals' assessment needs, including, but not limited to the use of interpreters in the individual's primary language and dialect, if feasible.	**Current findings on previous recommendations:** **Recommendations 1 and 2, October 2007:** • Ensure that examiners consider cultural aspects when choosing assessment instruments with individuals whose preferred language is not English. • Ensure that psychological assessments are provided in the individual's preferred language using interpreters or cultural brokers. **Findings:** ASH audited six charts of individuals whose primary/preferred language was not English, using items #22 (*psychologist endeavored to assess in the individual's own language*), #23 (*if not, a plan was identified to meet the individual's needs*), and #24 (*and the plan was implemented*), reporting 50% compliance on all items. According to the Senior Supervising Psychologist, the low compliance was because the IAPs had not been completed and not because the evaluations were conducted in a language other than the individuals' primary/preferred languages. This monitor reviewed 13 charts (AM, AOA, AR, BS, BS, DNM, EI, FGG, GCM, HC, IS, LSS and RBD). Eight of the IAPs in the charts (AM, AOA, BS, DNM, EI, FGG, HC and LSS) had conducted the assessments in the individual's primary/preferred language. Two of them (AR and GCM) contained documentation that the individuals were bi-lingual and preferred to have the evaluations in English. Three of the charts (BS, IS and RBD) did not contain IAPs. The preferred/primary language of the individuals included in the monitor's review individuals included Spanish, Persian, and Laotian. ASH had used examiners who spoke the individuals' native languages, interpreters, as well as inline interpreters (AT&T phone carrier) to

		meet the individuals' language needs. **Compliance:** Partial. **Current recommendations:** 1. Ensure that examiners consider cultural aspects when choosing assessment instruments with individuals whose preferred language is not English. 2. Ensure that psychological assessments are provided in the individual's preferred language using interpreters or cultural brokers.

3. Nursing Assessments		
		Methodology: Interviewed: 1. Cynthia Davis, Nurse Administrator, Central Nursing Services 2. Vickie Vinke, Health Services Specialist, Central Nursing Services 3. Donna Hunt, Health Services Specialist 4. Concha Silva, RN, Standards Compliance 5. Jeannine Doolin, RN, Standards Compliance 6. Belinda Roetker, RN, Standards Compliance Reviewed: 1. ASH's progress report and data 2. Reviewed the Nursing Admission Assessments, Integrated Assessments, and WRPs for the following 40 individuals: AB, AH, AHS, AJB, AR, BLB, CMC, DEB, DKL, DLB, DLM, DRK, DVL, ED, GEG, JAM, JC, JCA, JDP, JGC, JH, JJL, JKT, JLA, JMM, JOJ, JRF, KFB, MAM, MG, MIM, MM, MP, MSM, PRI, RM, TH, VA, VMH and WJH 3. Training Plan for Nursing Admission and Integrated Assessment Updates 4. Draft curriculum for Establishing Competency in Psychiatric Nursing and monitoring form Observed: Two WRPTs (30-day and 60-day) on Unit IV
D.3.a	Each State hospital shall develop standard nursing assessment protocols, consistent with generally accepted professional standards of care. These protocols shall address, at a minimum:	**Compliance:** Partial.
D.3.a.i	a description of presenting conditions;	**Current findings on previous recommendations:**

		Recommendation 1, October 2007: Implement the statewide Nursing Admission Assessment. **Findings:** ASH's progress report indicated that the Revised Statewide Nursing Admission and Integrated Nursing Assessment was implemented hospital-wide December 1, 2007. **Recommendation 2, October 2007:** Revise and implement the Nursing Assessment Competency Validation Form. **Findings:** ASH has not yet developed and implemented a competency validation process and data collection process for Nursing Assessment Competency. A draft of the curriculum for Establishing Competency in Psychiatric Nursing was submitted with the proposed competency validation monitoring form. ASH reported that this requirement would be implemented by June 1, 2008. **Recommendation 3, October 2007:** Continue to monitor this requirement. **Findings:** For this review, data from December 2007-February 2008 will be addressed since these data represent the new Statewide admission and integrated assessment tools. ASH's data from the DMH Nursing Admission Assessment audit based on an 85% mean sample of admissions (December 2007-February 2008) indicated 62% mean compliance that a description of the presenting conditions was documented.

		This monitor's review of 40 individuals' admission assessments (AB, AH, AHS, AJB, AR, BLB, CMC, DEB, DKL, DLB, DLM, DRK, DVL, ED, GEG, JAM, JC, JCA, JDP, JGC, JH, JJL, JKT, JLA, JMM, JOJ, JRF, KFB, MAM, MG, MIM, MM, MP, MSM, PRI, RM, TH, VA, VMH and WJH) found that most of the assessments did not adequately address the presenting conditions. In addition, a number of assessments had blank sections with no indication if the nurse asked about these areas or if the individual refused to answer. There were several assessments that did not have all areas of the current prescribed medications completed, without explanation. Most of the assessments included vital signs and complete information regarding allergies. Pain, use of assistive devices, and activities of daily living were consistently addressed on the assessments reviewed. There were blanks on a few assessments that indicated that either the physician or dietician was notified when the assessment indicated otherwise. In most cases the immediate alerts were adequately addressed. However, the section addressing immediate nursing interventions was not adequately addressed. Overall, most of the assessments were brief and lacked specific details regarding pertinent information. There needs to be continued training and mentoring to facilitate obtaining meaningful information during the admission process. **Current recommendations**: 1. Develop and implement the Nursing Assessment Competency Validation Form. 2. Continue to monitor this requirement.
D.3.a.ii	current prescribed medications;	56% mean compliance
D.3.a.iii	vital signs;	90% mean compliance

D.3.a.iv	allergies;	92% mean compliance
D.3.a.v	pain;	86% mean compliance
D.3.a.vi	use of assistive devices;	82% mean compliance
D.3.a.vii	activities of daily living;	90% mean compliance
D.3.a.viii	immediate alerts (e.g., escape risk, physical assault, choking risk, suicidal risk, homicide risk, fall risk, sexual assault, self-injurious behavior, arson, or fire setting); and	79% mean compliance for December 2007 and January 2008 (February data could not be interpreted)
D.3.a.ix	conditions needing immediate nursing interventions.	49% mean compliance for December 2007 and January 2008 (February data could not be interpreted)
D.3.b	Nursing may use a systems model (e.g., Johnson Behavioral System Model) for the nursing evaluation.	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Continue to monitor this requirement. **Findings:** ASH's Nursing policies and procedures have been revised to reflect the Wellness and Recovery Model. The statewide nursing Admission Assessments has been revised incorporating the Wellness and Recovery Model. **Recommendation 2, October 2007:** Provide data regarding staff training with WRP. **Findings:** Some staff have not yet received the basic training regarding the Wellness and Recovery Model. Consequently, a number of unit staff do

		not have the understanding of how the philosophy of the facility should be changing staff practices. See F.3.c **Compliance:** Partial. **Current recommendations**: 1. Continue to provide training to staff regarding Wellness and Recovery. 2. Continue to monitor this requirement.
D.3.c	Each State hospital shall ensure that all nurses responsible for performing or reviewing nursing assessments are verifiably competent in performing the assessments for which they are responsible. All nurses who are employed at Atascadero State Hospital shall have graduated based on an approved nursing program, shall have passed the NCLEX-RN and shall have a license to practice in the state of California.	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Implement the Nursing Assessment Competency Validation process. **Findings:** See D.3.a.i, Findings for Recommendation 2. **Recommendations 2 and 3, October 2007:** • Provide data regarding verification of nursing licenses. • Continue to monitor this requirement. **Findings:** ASH verifies the licenses of all newly hired and renewals for nursing staff through the California Board of Nurses licensure website. **Compliance:** Partial. **Current recommendations**: 1. Develop and implement the Nursing Assessment Competency Validation process.

		2. Continue to monitor this requirement.
D.3.d	Each State hospital shall ensure that nursing assessments are undertaken on a timely basis, and in particular, that:	**Compliance:** Partial.
D.3.d.i	Initial nursing assessments are completed within 24 hours of the individual's admission;	**Current findings on previous recommendations:** **Recommendation, October 2007:** Continue to monitor this requirement. **Findings:** ASH's data from the DMH Nursing Admission Assessment audit based on an 86% mean sample of admissions each month (N) for September 2007-February 2008 indicated 96% mean compliance that initial nursing assessments were completed within 24 hours of the individual's admission. This monitor's review of 40 admission assessments (AB, AH, AHS, AJB, AR, BLB, CMC, DEB, DKL, DLB, DLM, DRK, DVL, ED, GEG, JAM, JC, JCA, JDP, JGC, JH, JJL, JKT, JLA, JMM, JOJ, JRF, KFB, MAM, MG, MIM, MM, MP, MSM, PRI, RM, TH, VA, VMH and WJH) found that all were completed within 24 hours except for two that could not be determined due to missing pages (AR and GEG), three that had the "sections completed" area left blank (CMC, MM and RM), and one that stated the assessment was only partially completed (BLB). **Current recommendations**: Continue to monitor this requirement.
D.3.d.ii	Further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven	**Current findings on previous recommendations:**

	days of admission; and	**Recommendation 1, October 2007:** Continue to monitor this requirement. **Findings:** ASH's data from the DMH Nursing Integrated Assessment Audit based on an 85% mean sample of nursing integrated assessments due per review month (September 2007-February 2008) indicated 72% mean compliance that further nursing assessments are completed and integrated into the individual's therapeutic and rehabilitation service plan within seven days of admission. This monitor's review of 40 Nursing Integrated Assessments (AB, AH, AHS, AJB, AR, BLB, CMC, DEB, DKL, DLB, DLM, DRK, DVL, ED, GEG, JAM, JC, JCA, JDP, JGC, JH, JJL, JKT, JLA, JMM, JOJ, JRF, KFB, MAM, MG, MIM, MM, MP, MSM, PRI, RM, TH, VA, VMH and WJH) found that 23 were not completed within ASH's five-day required time frame (AH, AHS, BLB, CMC, DLB, DLM, DRK, ED, GEG, JGC, JJL, JLA, JMM, JKT, KFB, MG, MSM, PRI, RM, TH, VMH and WJH, and JC who did not have an integrated assessment in his chart). Although the EP requires a seven-day time frame, ASH reported that it requires a five-day time frame and audited using both the seven-day and five-day time limits for different months during this review, which accounted for a higher compliance rate for this requirement. ASH reported that the time frame audited for this requirement for the next review will be consistently five days. In addition, ASH reported that staffing issues and opening a new admissions unit had contributed to low compliance with the timeliness of completion of Integrated Assessments. **Recommendation 2, October 2007:** Provide accurate data regarding nursing participation in team meetings.

		Findings: ASH's data (for only Program IV) from the DMH WRP Observation Audit based on a 59% mean sample of scheduled WRPCs per review month (N) for September 2007-February 2008 indicated 77% mean compliance that the core Registered Nurse (or an acceptable substitute) attends the WRPC. **Other findings:** There was no nurse at either WRPT observed by this monitor. **Current recommendations**: 1. Ensure that a nurse attends all WRPTs. 2. Continue to monitor this requirement.
D.3.d.iii	Nursing assessments are reviewed every 14 days during the first 60 days of admission and every 30 days thereafter and updated as appropriate. The third monthly review shall be a quarterly review and the 12th monthly review shall be the annual review.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Develop and implement a monitoring system to address this requirement. **Findings:** ASH's progress report indicated that using the DMH Nursing Assessment monitoring tool, data collection for this requirement began on March 1, 2008 and data will be presented for the next review. **Current recommendations**: Provide data addressing this requirement.

4. Rehabilitation Therapy Assessments		
		Methodology: Interviewed: 1. Ladonna DeCou, Chief of Rehabilitation 2. Rachelle Rianda, Acting Supervising Rehabilitation Therapist 3. Terry Devine, Physical Therapist (contract) 4. Meg Benitez, Physical Therapist (contract) 5. Judy Curtis, Senior Vocational Rehabilitation Counselor Reviewed: 1. Recovery and Mall Services Organizational Chart draft (revised 1/11/08) 2. DMH Rehabilitation Therapy Service Manual draft 3. ASH Recovery Mall Services 4. AD #409 Rehabilitation Therapy Services 5. Integrated Assessment-Rehabilitation Therapy Section 6. Integrated Assessment-Rehabilitation Therapy Section instructions 7. DMH Rehabilitation Therapy Monitoring Form and Instructions (D4 monitoring tool for admission assessments) 8. DMH Rehabilitation Therapy Monitoring Tool and Instructions (IA-RTS audit) 9. DMH Rehabilitation Therapy IA-RTS Audit data for November and December 2007 RIAT Pilot assessments and January- February 2008 IA-RTS assessments 10. DMH Vocational Rehabilitation Assessment Tool and Instructions (approved 3/08, implemented after this review period) 11. DMH Vocational Rehabilitation Assessment Monitoring Tool and Instructions (approved 3/08, implemented after this review period) 12. DMH Occupational Therapy Focused Assessment and Instructions (approved 3/08, implemented after this review period) 13. DMH Occupational Therapy Focused Assessment Monitoring Tool

		and Instructions drafts (approved 3/08, implemented after this review period) 14. DMH Speech-Language Focused Assessment and Instructions (approved 3/08, implemented after this review period) 15. DMH Speech-Language Focused Assessment Monitoring Tool and Instructions (approved 3/08, implemented after this review period) 16. DMH Physical Therapy Focused Assessment and Instructions (approved 3/08, implemented after this review period) 17. DMH Physical Therapy Focused Assessment Monitoring Tool and Instructions (approved 3/08, implemented after this review period) 18. DMH Comprehensive Integrated Physical Rehabilitation Therapy Assessment and Instructions (approved 3/08, implemented after this review period) 19. DMH Comprehensive Integrated Physical Rehabilitation Therapy Assessment Monitoring Tool and Instructions (approved 3/08, implemented after this review period) 20. List of individuals who had November 2007-December 2007 RIAT Pilot assessments and January-February 2008 IA-RTS assessments 21. Records of the following19 individuals who had RIAT Pilot assessments from November 2007-December 2007 or IA-RTS assessments from January-February 2008: ADS, AL, EO, GAW, GCD, GCJ, JB, JCS, JEP ,JES, JSR, KNB, LAP, MJC, MWV, PVH, TDW, THT and VL 22. List of individuals who had Physical Therapy assessment/consultation from September 2007-February 2008 23. Records for the following seven individuals who had Physical Therapy assessment/consultation during the September 2007-February 2008 review period: FW, GD, JJ, JPM, LPM, MDH and WST 24. List of individuals who had Speech Therapy assessment/consultation from September 2007-February 2008 25. Records for the following seven individuals who had Speech Therapy assessment/consultation during the September 2007-

		February 2008 review period: EVT, JDP, JKC, LAB, RLS, RPD and RSP 26. List of individuals who had Vocational Rehabilitation assessment from September 2007-February 2008 27. Records for the following 11 individuals who had a Vocational Assessment from September 2007-February 2008: CBC, CSR, DDD, JIL, JKS, LHJ, MWN, PCK, RCH, RDW and RSA 28. Training roster and competency scores for IA-RTS
D.4.a	Each State hospital shall develop standard rehabilitation therapy assessment protocols, consistent with generally accepted professional standards of care, for satisfying the necessary components of a comprehensive rehabilitation therapy assessment.	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Revise and implement the Rehabilitation Therapy Manual to reflect changes including departmental integration and re-structuring, a description of collaboration among disciplines and therapy teams within the department, and any revised or new Rehabilitation Therapy Services procedures. **Findings:** The Rehabilitation Therapy organizational chart was revised and the draft is pending implementation. The draft includes all Rehabilitation Therapy disciplines (Psychosocial Rehabilitation Therapists, Vocational Rehabilitation Services, and Physical, Occupational, and Speech Therapists) under the Rehabilitation Therapy Service Chief. AD #409 Rehabilitation Therapy Services was revised to include a general description of Rehabilitation Therapy Services, including all Rehabilitation Therapy disciplines, and approved 12/18/07. The draft of the statewide Rehabilitation Therapy Manual was developed in December 2007, and has been subsequently updated as procedures and processes have evolved. The current draft addresses the role of the Rehabilitation Therapist in the WRP, as well as the role of the POST team, Occupational Therapist, Physical Therapist, Speech Therapist, and Vocational Rehabilitation Counselors and Instructors. The manual

		includes the Rehabilitation Therapist's role in acting as a liaison to report findings of the POST disciplines and Vocational Rehabilitation Services. However, it is noted that a separate Speech Therapy (Language and Cognitive Services) Manual exists, and the contents of this manual have not been integrated into the Rehabilitation Therapy Manual. In addition, the Language and Cognitive Services Manual has not been converted to reflect practices consistent with Rehabilitation Therapy practices and procedures in regards to EP requirements for assessments, monitoring and documentation of progress. For example, the Language and Cognitive Services Manual states that the PSR Mall Progress notes should be used to document progress with direct 1:1 treatment, which is inaccurate, as this note is used only for PSR Mall groups. Procedure drafts for Physical and Speech Therapy Services have been developed and should be revised to ensure alignment with Rehabilitation Therapy practices and procedures in regards to EP requirements for assessments, monitoring and documentation of progress. An Occupational Therapy Services procedure has not been developed. The Rehabilitation Therapy Manual has been updated to include newly developed procedures for focused assessments (POST and Vocational Rehabilitation), assessment instructions, and monitoring tools and instructions. The Manual should continue to be updated as procedures and systems develop. **Recommendation 2, October 2007:** Revise and implement the Integrated Rehabilitation Therapy Assessment and instructions based on findings of pilot of Integrated Assessment-Rehabilitation Therapy Section and collaboration with other state facilities.

		Findings: The IA-RTS and instructions were approved and implemented on 1/16/08 and implementation began on admission units on 1/07/08. This was verified upon record review of individuals who received IA-RTS assessments in January and February 2008. **Recommendation 3, October 2007:** Develop and implement Rehabilitation Therapy protocols/ instruction sheets for Vocational Rehabilitation, Physical Therapy, Speech Therapy, Occupational Therapy, and Comprehensive Physical Rehabilitation (POST) assessments that correspond with assessment tools/instructions at other state facilities. **Findings:** Vocational Rehabilitation, Physical Therapy, Speech Therapy, Occupational Therapy, and Comprehensive Physical Rehabilitation (POST) assessments and instructions were approved and implemented in March 2008, which is after the September 2007-February 2008 review period. Therefore, compliance with this recommendation will be assessed during the next review. According to interview, the Comprehensive Physical Rehabilitation Therapy assessment and Occupational Therapy assessment tools have not been yet implemented due to limited staffing, and lack of Occupational Therapy services (for assessment and treatment). **Recommendation 4, October 2007:** Obtain Occupational Therapy Services. **Findings:** This recommendation has not been met; currently no Occupational Therapy Services are available for the provision of Occupational Therapy assessment or Comprehensive Integrated Physical

		Rehabilitation Therapy assessment. According to facility report, a position was offered to an Occupational Therapist on February 5; she accepted the offer and is currently being processed through Occupational Health Clinic prior to employment. **Recommendation 5, October 2007:** Develop and implement a plan to ensure that individuals who would benefit from a Comprehensive Integrated Rehabilitation Assessment are referred for this service by the WRPT. **Findings:** This recommendation has not been met. **Compliance:** Partial. **Current recommendations:** 1. Revise and implement the Department of Mental Health Rehabilitation Therapy Service Manual draft based on changes, new protocols and procedures, and system development; ensure that all discipline-specific service procedures and manuals are integrated into and consistent with Rehabilitation Therapy practice in relation to Wellness and Recovery model and EP requirements. 2. Implement focused assessment tools and instructions including Physical, Occupational, Speech, Vocational Rehabilitation, and Comprehensive Physical Rehabilitation Therapy assessments, and ensure that process/format is consistent with those of the other three state hospitals. 3. Develop and implement a plan to ensure that individuals (both new admissions and individuals residing at ASH) who would benefit from a Comprehensive Physical Rehabilitation Therapy assessment or a Vocational Rehabilitation assessment are referred for this service by the WRPT.

D.4.b	Each State hospital shall ensure that each individual served shall have a rehabilitation assessment that, consistent with generally accepted professional standards of care:	**Compliance:** Partial.
D.4.b.i	Is accurate and comprehensive as to the individual's functional abilities;	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Develop and implement monitoring tool(s) for Physical, Occupational, and Speech Therapy Assessments, Vocational Rehabilitation Assessments, and Comprehensive Physical Rehabilitation Assessments (POST) to ensure that all assessments are timely and provide a thorough assessment of functional ability as opposed to a focus on dysfunction and disability. **Findings:** Vocational Rehabilitation, Physical Therapy, Speech Therapy, Occupational Therapy, and Comprehensive Physical Rehabilitation (POST) assessment audit tools and instructions and D.4 monitoring tools for focused assessments have been approved and were implemented in March 2008, which is after the September 2007-February 2008 review period. Therefore, compliance with this recommendation will be assessed during the next review. No monitoring data is available to the time of this review regarding EP compliance for focused assessments. **Recommendation 2, October 2007:** Revise and implement the Integrated Assessment--Rehabilitation Therapy Section Monitoring Tool and instructions based on findings from pilot and collaboration with other state facilities. **Findings:** The MH-C 9044 Rehabilitation Therapy Assessment Monitoring Form

		and Instructions was developed to monitor D.4 admission (Integrated Assessment-Rehabilitation Therapy Section, abbreviated as IA-RTS) assessments and was approved 2/21/08, but implemented in March 2008. According to review of facility data using the previous monitoring tool, it is noted that the sample size requirement of monitoring for 100% of admission assessments has not been met. **Recommendation 3, October 2007:** Ensure that all individual objectives are functional, meaningful, and measurable. **Findings:** According to review of training database and competency scores, 30 out of 37 Rehabilitation Therapists have been trained to at least 90% competency on the Integrated Assessment-Rehabilitation Services section, which includes training on how to write objectives in functional, observable, and measurable terms. The IA-RTS assessment instructions include information related to writing functional, observable and measurable objectives. Upon review of a sample of IA-RTS admission assessments and objectives for individuals participating in observed PSR Mall groups, it was noted that 47% of RT objectives were functional, measurable, and observable. Upon review of a sample of records of individuals receiving direct Physical Therapy treatment, it was noted that 38% of objectives were functional and 75% were measurable. Upon review of a sample of records of individuals receiving direct Speech Therapy treatment, it was noted that 86% of objectives were functional and 86% were measurable.

		Recommendation 4, October 2007: Establish inter-rater reliability for all audit/monitoring tools prior to implementation. **Findings:** Inter-rater agreement has not been established as there is currently only one RT Supervisor completing audits. **Other findings:** According to audit data for November-December 2007 Rehabilitation Integrated Assessment Team (RIAT) pilot assessments and January-February 2008 IA-RTS assessments, 5% of assessments were timely and 39% of assessments were accurate and comprehensive as to the individual's functional abilities. Record review of November-December 2007 RIAT pilot assessments and January-February 2008 IA-RTS assessments found that 5% of assessments were timely, 95% of IA-RTS assessments were complete, 74% were comprehensive, and 26% addressed functional abilities. No facility audit data was available for Physical Therapy assessments. Record review of Physical Therapy Assessments found that 43% of assessments were timely, 100% of assessments were complete, 43% were comprehensive, and 57% addressed functional abilities. No facility audit data was available for Speech Therapy assessments. Review of Speech Therapy Assessments showed that 71% of assessments were timely and 100% of assessments were complete, comprehensive and addressed functional abilities. No facility audit data was available for Vocational Rehabilitation assessments. Record review of Vocational Rehabilitation assessments found that 73% of assessments were timely, 100% of assessments

		were complete, 90% were comprehensive, and none addressed functional abilities. **Current recommendations**: 1. Implement D4 monitoring tool(s) for admission and focused assessments that report data on EP cells pertaining to all Rehabilitation Therapy assessments (Integrated Admission and focused) according to DMH format/standards. 2. Ensure that auditors have received training on monitoring tools and inter-rater agreement has been established for Integrated Assessment-Rehabilitation Services section and focused assessments monitoring prior to implementation. 3. Ensure that all Rehabilitation Services admission and focused assessments are accurate and comprehensive as to the individual's functional abilities. 4. Ensure that all staff has been trained to competency on assessment protocols and instructions.
D.4.b.ii	Identifies the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care; and	**Current findings on previous recommendation:** **Recommendation:** Ensure that all assessments identify the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care. **Findings:** According to audit data for November-December 2007 RIAT pilot assessments and January-February 2008 IA-RTS assessments, 44% identified skills and supports needed to transfer to the next level of care. No facility data was provided for compliance with identification of functional status. Record review of IA-RTS assessments from November-December

		2007 RIAT pilot assessments and January-February 2008 IA-RTS assessments found that 68% of assessments identified current functional status and 53% of assessments identified skills and supports needed to facilitate transfer to the next level of care. No facility audit data was available for Physical Therapy assessments. Record review of Physical Therapy assessments found that none of assessments identified current functional status or identified skills and supports needed to facilitate transfer to the next level of care. No facility audit data was available for Speech Therapy assessments. Review of Speech Therapy assessments found that 100% of assessments identified current functional status and identified skills and supports needed to facilitate transfer to the next level of care. No facility audit data was available for Vocational Rehabilitation assessments. Review of Vocational assessments found that none of assessments identified current functional status and 27% of assessments identified skills and supports needed to facilitate transfer to the next level of care. **Current recommendation**: Ensure that all Rehabilitation Services admission and focused assessments identify the individual's current functional status and the skills and supports needed to facilitate transfer to the next level of care.
D.4.b.iii	Identifies the individual's life goals, strengths, and motivation for engaging in wellness activities.	**Current findings on previous recommendation:** **Recommendation:** Ensure that all assessments identify the individual's life goals, strengths, and motivation for engaging in wellness activities.

		Findings: According to facility audit data for November-December 2007 RIAT pilot assessments and January-February 2008 IA-RTS assessments, 59% of assessments identified the individual's life goals, 44% addressed strengths and 38% identified motivation for engaging in wellness activities. Record review of November-December 2007 RIAT pilot assessments and January-February 2008 IA-RTS assessments found that 95% of assessments identified individual's life goals, 95% addressed strengths, and 100% identified motivation for engaging in wellness activities. No facility audit data was available for Physical Therapy assessments. Record review of Physical Therapy assessments found that none identified the individual's goals, addressed strengths or identified the individual's motivation for engaging in wellness activities. No facility audit data was available for Speech Therapy assessments. Review of Speech Therapy assessments found that 60% of assessments identified the individual's goals, 40% addressed strengths and 40% identified motivation for engaging in wellness activities. No facility audit data was available for Vocational Rehabilitation assessments. Review of Vocational assessments found that 18% of assessments identified the individual's goals, 100% addressed strengths and 64% identified motivation for engaging in wellness activities. **Current recommendation**: Ensure that all Rehabilitation Services admission and focused assessments identify the individual's life goals, strengths, and motivation for engaging in wellness activities.

D.4.c	Each State hospital shall ensure that all clinicians responsible for performing or reviewing rehabilitation therapy assessments are verifiably competent in performing the assessments for which they are responsible	**Current findings on previous recommendation:** **Recommendation, October 2007:** Provide competency-based training to all Rehabilitation Services staff regarding changes in departmental procedures, and to appropriate staff regarding developed/revised assessment protocols and instructions on a discipline-/team-specific basis. **Findings:** According to review of training database and competency scores, 30 out of 37 Rehabilitation Therapists have been trained to at least 90% competency on the Integrated Assessment-Rehabilitation Services section. A system for trend analysis of IA-RTS audit findings and resultant group mentoring and trend -training has not been initiated. According to facility report, individual training based on audit data analysis has been ongoing, though no documentation was provided. Competency-based training regarding all focused assessments has not been completed. **Compliance:** Partial. **Current recommendations**: 1. Ensure that staff who are performing assessments (admission and focused) have been trained to competency. 2. Develop and implement a system by which to analyze audit data for focused assessments (Vocational Rehabilitation, Occupational, Physical, and Speech Therapy assessments and Comprehensive Physical Rehabilitation assessments) and provide feedback to staff regarding performance improvement and recommendations for

		training/CEU courses based on these findings, and track CEU courses attended by Rehabilitation Therapy staff. 3. Develop and implement a system by to analyze IA-RTS audit data and provide group trend-based training.
D.4.d	Each State hospital shall ensure that all rehabilitation therapy assessments of all individuals who were admitted to each State hospital before the Effective Date hereof shall be reviewed by qualified clinicians and, as indicated, revised to meet the criteria in § [IV.D.2], above.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Ensure that all individuals admitted to ASH prior to March 1, 2007 receive an Integrated Rehabilitation Therapy Assessment within the next six months. **Findings:** According to facility report, the plan is to administer the IA-RTS to these individuals at the time of each individual's annual assessment in order to complete all D.4.d assessments in the period of one year. The facility did not provide data regarding individuals admitted prior to June 1, 2006 who may have received an IA-RTS assessment already. **Compliance:** Partial. **Current recommendation**: Ensure that all individuals admitted to ASH prior to June 1, 2006 receive an Integrated Assessment-Rehabilitation Therapy Section Assessment within the next twelve months.

5. Nutrition Assessments		
D.5	Each State hospital shall provide nutrition assessments, reassessments, and interventions consistent with generally accepted professional standards of care. A comprehensive nutrition assessment will include the following:	**Methodology:** Interviewed: 1. Erin Dengate, Assistant Director of Dietetics 2. Dawn Hartman, Clinical Dietitian Reviewed: 1. Nutrition Care Monitoring audit data for September 2007- February 2008 for each assessment type 2. Lists of individuals with Nutrition Care Assessments due from September 2007- February 2008 for each assessment type 3. Records for the following four individuals receiving type D.5.a assessments from September 2007- February 2008: AAD, APL, RE and TE 4. Records for the following three individuals receiving type D.5.b assessments from September 2007- February 2008: DRS, SAJ and SB 5. Records for the following seven individuals receiving type D.5.d assessments from September 2007- February 2008: GDC, JCA, JFD, MGM, SA, SC and TSK 6. Records for the following five individuals receiving type D.5.e assessments from September 2007- February 2008: ARM, DMB, KLW, LSS and RKD 7. Record for the following individual receiving type D.5.f assessment from September 2007- February 2008: EJ 8. Records for the following 14 individuals receiving type D.5.g assessments from September 2007- February 2008: ALW, CDR, DAP, DLD, HK, JLB, JRR, JRW, MRM, PG, RD, RDS, RJD, RJL 9. Records for the following nine individuals receiving type D.5.i assessments from September 2007- February 2008: CE, COH, EI, JC, MER, MM, REC, RS and RW 10. Records for the following 11 individuals receiving type D.5.j.i

		assessments from September 2007- February 2008: AG, BG, BPN, CTS, CV, DAW, EW, GP, JSG, MW, WJW 11. Records for the following six individuals receiving type D.5.j.ii assessments from September 2007- February 2008: EA, JCT, KBG, NMK, PP, TSM
D.5.a	For new admissions with high risk referral (e.g., type I diabetes mellitus, enteral/parenteral feeding, dysphagia/recent choking episode), or upon request by physician, a comprehensive Admission Nutrition Assessment will be completed within 24 hours of notification to the dietitian.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Continue current practice. **Findings:** According to facility report, six individuals were scheduled for type D.5.a assessments during the September 2007- February 2008 review period, and six records were audited using the Nutrition Care Monitoring Tool. This meets the sample size requirement of 100%. According to Nutrition Assessment audit data for the September 2007- February 2008 review period, 83% of assessments were completed on time; 100% had complete subjective findings, complete objective findings and a correctly formulated nutrition diagnosis; 67% had individualized and measurable goals; and 17% had appropriate recommendations. Record review of a sample of individuals requiring type D.5.a assessments during the September 2007- February 2008 review period found that 75% of assessments were completed on time; 100% had complete subjective findings, complete objective findings and a correctly formulated nutrition diagnosis; 75% had individualized and measurable goals; and 75% had appropriate recommendations. **Compliance:** Partial.

		Current recommendation: Continue current efforts to achieve compliance.
D.5.b	For new admissions directly into the medical-surgical unit, a comprehensive Admission Nutrition Assessment will be completed within 3 days of admission.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Continue current practice. **Findings:** According to facility report, five individuals were scheduled for type D.5.b assessments during the September 2007- February 2008 review period, and five records were audited using the Nutrition Care Monitoring Tool. This meets the sample size requirement of 100%. According to Nutrition Assessment audit data for the September 2007- February 2008 review period, 100% of assessments were completed on time and had complete subjective findings, complete objective findings and a correctly formulated nutrition diagnosis; 80% had individualized and measurable goals; and 80% had appropriate recommendations. Record review of a sample of individuals requiring type D.5.b assessments during the September 2007- February 2008 period found that 100% of assessments were completed on time and had complete subjective findings, complete objective findings and a correctly formulated nutrition diagnosis; 33% had individualized and measurable goals; and 33% had appropriate recommendations. **Compliance:** Partial. **Current recommendation**: Continue current efforts to achieve compliance.

D.5.c	For new admissions directly into the skilled nursing facility unit, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.	Not applicable. ASH does not have a skilled nursing facility unit.
D.5.d	For new admissions with identified nutritional triggers from Nursing Admission Assessment or physician's consult (e.g., for severe food allergies, tube feeding, extensive dental problems or dental surgery, NPO/clear liquid diet for more than three days, uncontrolled diarrhea/vomiting more than 24hrs, and MAOI, as clinically indicated), a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Continue current practice. **Findings:** According to facility report, 141 individuals were scheduled for type D.5.d assessments during the September 2007- February 2008 review period, and 131 records were audited using the Nutrition Care Monitoring Tool. This does not meet the sample size requirement of 100%. According to Nutrition Assessment audit data for the September 2007- February 2008 review period, 83% of assessments were completed on time, 96% had complete subjective findings, 99% had complete objective findings, 91% had a correctly formulated nutrition diagnosis, 58% had individualized and measurable goals and 76% had appropriate recommendations. Record review of a sample of individuals requiring type D.5.d assessments during the September 2007- February 2008 found that 67% of assessments were completed on time, 86% had complete subjective findings, 57% had complete objective findings, 100% had a correctly formulated nutrition diagnosis, 71% had individualized and measurable goals, and 71% had appropriate recommendations. **Compliance:** Partial.

		Current recommendation: Continue current efforts to achieve compliance.
D.5.e	For new admissions with therapeutic diet orders for medical reasons, a comprehensive Admission Nutrition Assessment will be completed within 7 days of admission.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Continue current practice. **Findings:** According to facility report, nine individuals were scheduled for type D.5.e assessments during the September 2007- February 2008 review period and nine records were audited using the Nutrition Care Monitoring Tool. This meets the sample size requirement of 100%. According to Nutrition Assessment audit data for the September 2007- February 2008 review period, 63% of assessments were completed on time, 100% had complete subjective findings and complete objective findings, 73% had a correctly formulated nutrition diagnosis, 45% had individualized and measurable goals, and 44% had appropriate recommendations. Record review of a sample of individuals requiring type D.5.e assessments during the September 2007- February 2008 found that 80% of assessments were completed on time, 100% had complete subjective findings, 80% had complete objective findings, 40% had a correctly formulated nutrition diagnosis, 20% had individualized and measurable goals, and 40% had appropriate recommendations. **Compliance:** Partial. **Current recommendation**: Continue current efforts to achieve compliance.

D.5.f	For individuals with therapeutic diet orders for medical reason after admission, a comprehensive Admission Nutrition Assessment will be completed within 7 days of the therapeutic diet order but no later than 30 days of admission.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Continue current practice. **Findings:** According to facility report, two individuals were scheduled for type D.5.f assessments during the September 2007- February 2008 review period and two records were audited using the Nutrition Care Monitoring Tool. This meets the sample size requirement of 100%. According to Nutrition Assessment audit data for the September 2007- February 2008 review period, 50% of assessments were completed on time and 100% had complete subjective findings, complete objective findings, a correctly formulated nutrition diagnosis, individualized and measurable goals and appropriate recommendations. A weighted mean of all assessment line items of 96% compliance was reported. Record review of a sample of one individual requiring type D.5.f assessment during the September 2007- February 2008 indicated that the assessment was completed on time, had complete subjective findings, complete objective findings, a correctly formulated nutrition diagnosis, individualized and measurable goals, and appropriate recommendations. **Compliance:** Partial. **Current recommendation**: Continue current efforts to achieve compliance.

D.5.g	For all other individuals, a comprehensive Admission Nutrition Assessment will be completed within 30 days of admission.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Continue current practice. **Findings:** According to facility report, 394 individuals were scheduled for type D.5.g assessments during the September 2007- February 2008 review period, and 96 records were audited using the Nutrition Care Monitoring Tool (24%). This surpasses the sample size requirement of 20% when N is greater than 20. According to Nutrition Assessment audit data for the September 2007- February 2008 review period, 70% of assessments were completed on time, 89% had complete subjective findings, 99% had complete objective findings, 89% had a correctly formulated nutrition diagnosis, 47% had individualized and measurable goals and 82% had appropriate recommendations. Record review of a sample of individuals requiring type D.5.g assessments during the September 2007- February 2008 period found that 93% of assessments were completed on time, 100% had complete subjective findings, 79% had complete objective findings, 93% had a correctly formulated nutrition diagnosis, 57% had individualized and measurable goals and 71% had appropriate recommendations. **Compliance:** Partial. **Current recommendation**: Continue current efforts to achieve compliance.

D.5.h	Acuity level of an individual at nutritional risk will be determined by Nutritional Status Type ("NST") which defines minimum services provided by a registered dietitian.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Continue current practice. **Findings:** Nutrition Assessment audit data (473 assessments audited out of 1530 assessments completed for a 31% sample) of all assessment types completed from September 2007- February 2008 indicated that a weighted average of 86% of Nutrition Care assessments had evidence of a correctly assigned NST level. Record review of a sample of all assessment types due and completed for September 2007- February 2008 found that a weighted average of 92% of assessments audited contained evidence of a correctly assigned NST level. **Compliance:** Partial. **Current recommendations**: Continue current efforts to achieve compliance.
D.5.i	The frequency of a comprehensive Nutrition Assessment Update will be determined by the NST. Updates should include, but not be limited to: subjective data, weight, body-mass index ("BMI"), waist circumference, appropriate weight range, diet order, changes in pertinent medication, changes in pertinent medical/psychiatric problems, changes in nutritional problem(s), progress toward goals/objectives, effectiveness of interventions, changes in goals/plan, recommendations, and follow-	**Current findings on previous recommendation:** **Recommendation, October 2007:** Continue current practice. **Findings:** According to facility report, 512 individuals were scheduled for type D.5.i assessments during the September 2007- February 2008 review period and 71 records were audited using the Nutrition Care Monitoring Tool (17%). This does not meet the sample size requirement of 20% or

	up as needed.	N=n if N less than 20. According to Nutrition Assessment audit data for the September 2007- February 2008 review period, 45% of assessments were completed on time, 91% had complete subjective findings, 85% had complete objective findings, 87% had a correctly formulated nutrition diagnosis, 29% had individualized and measurable goals and 74% had appropriate recommendations. Record review of a sample of individuals requiring type D.5.i assessments during the September 2007- February 2008 found that 67% of assessments were completed on time, 100% had complete subjective findings, 56% had complete objective findings, 56% had a correctly formulated nutrition diagnosis, 56% had individualized and measurable goals and 67% had appropriate recommendations. According to facility report, poor compliance with timeliness and completion of type D.5.i assessments is attributable to low staffing ratios. As of the week of this review, 80 type D.5.i Nutrition Care Assessments due during the September 2007-February 2008 review period have not yet been completed. **Compliance:** Partial. **Current recommendation:** Continue current efforts to achieve compliance.
D.5.j.i	Individuals will be reassessed when there is a significant change in condition.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Continue current practice.

		Findings: According to facility report, 251 individuals were scheduled for type D.5.j.i assessments during the September 2007- February 2008 review period and 111 records were audited using the Nutrition Care Monitoring Tool (44%). This surpasses the sample size requirement of 20% or N=n if N less than 20. According to Nutrition Assessment audit data for September 2007-February 2008, for type j.i. referral assessments, 85% of assessments were completed on time, 97% had complete subjective findings, 79% had complete pertinent objective findings, 87% had a correctly formulated nutrition diagnosis, 72% had individualized and measurable goals and 69% had appropriate recommendations. Record review of a sample of individuals receiving type j.i. assessments during the review period of September 2007- February 2008 found that 91% of assessments were completed on time, 100% had complete subjective findings, 82% had complete pertinent objective findings, 82% had a correctly formulated nutrition diagnosis, 45% had individualized and measurable goals and 73% had appropriate recommendations. According to facility report, Dietitians continue to receive referrals for significant weight changes. However, Nutrition Policy and Procedure #808, Nutrition Referral Process states that only weight loss < BMI 18.5 receive urgent response (referral response within seven days). All other significant weight changes are addressed during monthly weight monitoring, with review and contact note provided by the Dietitian and discussion by the WRPT as needed. Currently, response to referrals for significant weight changes appears to be affecting the timeliness of other assessment types and of higher acuity or priority referrals. In addition, these referrals appear to be redundant, as the current hospital process for monthly weight

		monitoring addresses significant weight changes without the need for referral. **Compliance:** Partial. **Current recommendation**: Continue current efforts to achieve compliance.
D.5.j.ii	Every individual will be assessed annually.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Continue current practice. **Findings:** According to facility report, 210 individuals were scheduled for type D.5.j.ii assessments during the September 2007- February 2008 review period, and 42 records were audited using the Nutrition Care Monitoring Tool (20%). This meets the sample size requirement of 20% or N=n if N less than 20. According to Nutrition Assessment audit data for the September 2007-February 2008 review period, 41% of assessments were completed on time, 78% had complete subjective findings, 98% had complete objective findings, 87% had a correctly formulated nutrition diagnosis, 44% had individualized and measurable goals and 70% had appropriate recommendations. Record review of a sample of individuals with completed type D.5.j.ii assessments during the September 2007- February 2008 found that 86% of assessments were completed on time, 86% had complete subjective findings, 86% had complete objective findings, 100% had a correctly formulated nutrition diagnosis, 29% had individualized and

		measurable goals and 57% had appropriate recommendations. According to facility report, poor compliance with timeliness and completion of type D.5.j.ii assessments is attributable to low staffing ratios. As of the week of this review, 90 type j.ii. Nutrition Care Assessments due during the September 2007-February 2008 review period have not yet been completed. **Compliance:** Partial. **Current recommendation**: Continue current efforts to achieve compliance.

6. Social History Assessments		
	Each State hospital shall ensure that each individual has a social history evaluation that, consistent with generally accepted professional standards of care:	**Methodology:** Interviewed: 1. Individuals JC and TF 2. Alice Dodge, LCSW, Social Work 3. Donna Nelson, Standards Compliance Director 4. Janet Bouffard, LCSW, Chief of Social Work 5. John De Morales, Executive Director 6. Louis Santiago, SPT, BY CHOICE Coordinator. 7. Matt Hannessey, PhD, Psychologist, Mall Director 8. Sherie Colleen, LCSW, Social Work Reviewed: 1. Charts of the following 19 individuals: DEM, DM, DO, ET, FH, JN, MM, MMM, MSM, MTM, MW, RDM, RDS, REA, RM, SB, SW, TWS and WM 2. DMH Social History Assessment Monitoring Form -30 Day 3. DMH Social History Assessment Monitoring Form 4. EPPI Team Progress Report 5. Integrated Assessment: Social Work Section 6. List of individuals assessed to need family education 7. Social History Assessment Monitoring Form Instructions Observed: 1. WRPC for CM (Program III, Unit 21) 2. WRPC for MG (Program IV, Unit 9A)
D.6.a	Is, to the extent reasonably possible, accurate, current and comprehensive;	**Current findings on previous recommendations:** **Recommendations 1 and 2, October 2007:** • Implement the five-day and 30-day assessments in a timely fashion and improve the quality of the assessments.

		• Align monitoring tools with the EP. **Findings:** ASH audited 50 charts using items #1 (*accurate*), #2 (*current*), and #3 (*comprehensive*) from the DMH Social Work Integrated Assessment Monitoring Form, reporting, 24%, 0% and 39% compliance respectively. ASH also audited 22 charts using items #1 (*accurate*), #2 (*current*), and #3 (*comprehensive*) from the DMH 30-Day Social Work Assessment Monitoring form, reporting 2%, 5% and 0% compliance respectively. This monitor's documentation review found that low compliance resulted from absence of observation of the individual as part of the assessment, and incomplete review of source documents. According to the Chief of Social Work, timeliness of the Social Work Integrated Assessments and the 30-day Social Work Assessments was poor due to staffing shortage and transcription delay. This monitor reviewed 14 charts to evaluate the Integrated Assessments: Social Work Section (DEM, DM, DO, ET, FH, JN, MM, MSM, MTM, MW, RDM, RM, SB and WM). Seven assessments were timely (DEM, DM, FH, JN, MTM, MW and RM), and seven were untimely (DO, ET, MM, MSM, RDM, SB and WM). Four were conducted in a timely fashion by the Social Workers (ET, MM, MTM and SB), but the assessments did not get to the team on time due to transcription delays. Eight of the assessments (DM, DO, ET, FH, JN, RDM, RM and SB) were incomplete and/or inaccurate. This monitor also reviewed 15 charts (DEM, DM, DO, ET, FH, JN, MM, MMM, MSM, MTM, MW, RDM, RM, SB and WM) to evaluate the 30-day

		Social Work Assessments. Five assessments were timely (DM, FH, JN, RM and SB), and ten were untimely (DEM, DO, ET, MM, MMM, MSM, MTM, MW, RDM and WM). Two were untimely (FH and SB) due to transcription delay. Six (DM, ET, FH, RM, SB and SM) were incomplete and/or inaccurate. According to the Chief of Social Work, the DMH monitoring tool was approved on January 29, 2008 and implemented on February 1, 2008. **Compliance:** Partial. **Current recommendations**: Implement the five-day and 30-day assessments in a timely fashion and improve the quality of the assessments.
D.6.b	Expressly identifies factual inconsistencies among sources, resolves or attempts to resolve inconsistencies, and explains the rationale for the resolution offered;	**Current findings on previous recommendations:** **Recommendations 1 and 2, October 2007:** • Ensure that social workers identify and address the inconsistencies in current assessments. • Monitor factual inconsistencies in social histories and revise to correct the inconsistencies. **Findings:** ASH audited 22 charts using items #4 (*identifies factual inconsistencies*), #5 (*resolves or attempts to resolve inconsistencies*), and #6 (*offers rationale for the resolutions*) from the 30-Day DMH Social Work Assessment Monitoring Form, reporting 5%, 9% and 5% compliance respectively. This monitor reviewed 12 charts (DEM, DM, DO, FH, JN, MM, MMM, MSM, MTM, MW, RDM and RM) to evaluate the 30-Day Social Work

		Assessments for documentation of factual inconsistencies. Seven of the charts (DEM, MM, MMM, MSM, MTM, MW and RDM) did not contain the 30-day assessments. Two (DO and JN) had identified and resolved factual inconsistencies and three (DM, FH and RM) did not. **Compliance:** Partial. **Current recommendations:** 1. Ensure that social workers identify and address the inconsistencies in current assessments. 2. Monitor factual inconsistencies in social histories and revise to correct the inconsistencies.
D.6.c	Is included in the 7-day integrated assessment and fully documented by the 30th day of an individual's admission; and	**Current findings on previous recommendations:** **Recommendations 1 and 2, October 2007:** • Ensure all SW Integrated Assessments are completed and available to the WRPT before the seven-day WRPC. • Ensure that all 30-day social histories are completed and available to the individual's WRPT by the 30th day of admission. **Findings:** ASH audited 50 charts using items #7 (*completed and filed in the medical records in a timely manner*) from the DMH Social Work Integrated Assessment monitoring Form, reporting 38% compliance for timely completion and 46% compliance for timely filing in the medical records. ASH also audited 22 charts using item #8 (*completed and filed in the medical records in a timely manner*) from the 30-day DMH Social Work Assessment Monitoring Form, reporting 5% compliance for timely completion and 9% compliance for timely filing in the medical records.

		This monitor reviewed 14 charts (DEM, DM, DO, ET, FH, JN, MM, MSM, MTM, MW, RDM, RM, SB and WM) to evaluate timeliness of the Social Work Integrated Assessments. Seven of the assessments in the charts (DEM, DM, FH, JN, MTM, MW and RM) were timely and seven (DO, ET, MM, MSM, RDM, SB and WM) were untimely. This monitor reviewed 15 charts (DEM, DM, DO, ET, FH, JN, MM, MMM, MSM, MTM, MW, RDM, RM, SB and WM) to evaluate timeliness of the 30-day Social Work Assessments. Five of the assessments in the charts (DM, FH, JN, RM and SB) were timely and ten (DEM, DO, ET, MM, MMM, MSM, MTM, MW, RDM and WM) were untimely. **Compliance:** Partial. **Current recommendations:** 1. Ensure all SW Integrated assessments are completed and available to the WRPT before the seven-day WRPC. 2. Ensure that all 30-day social histories are completed and available to the individual's WRPT by the 30th day of admission.
D.6.d	Reliably informs the individual's interdisciplinary team about the individual's relevant social factors and educational status.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Ensure that social history assessments contain sufficient information on the individual's social factors and educational status to reliably inform the individual's WRPT. **Findings:** ASH audited 50 charts using items #10 (*educational status*) from the DMH Social Work Integrated Assessment monitoring Form, reporting 38% compliance.

		This monitor reviewed seven charts (DM, DO, ET, FH, JN, RM and SB) to evaluate documentation of the individuals' social factors and educational status in the 30-day Social Work Assessment. Two of the assessments in the charts (DO and JN) documented the individual's educational status, and five of them (DM, ET, FH, RM and SB) did not. Five of the assessments (DO, FH, JN, RM and SB) had documented the individual's social factors and two of them (DM and ET) did not. **Compliance:** Partial. **Current recommendations**: Ensure that social history assessments contain sufficient information on the individual's social factors and educational status to reliably inform the individual's WRPT.

7. Court Assessments		
		Methodology: Interviewed: 1. David Fennel, MD, Chair, Forensic Review Panel and Chief, Forensic Psychiatry Program 2. Jennifer Brush, Forensic Services Manager Reviewed: 1. The charts of the following six individuals who were admitted under PC 1026: AFJ, CG, JN, PP, PR and RB 2. The charts of the following six individuals who were admitted under PC 1370: AR, CCB, DC, RC, RS and TS 3. DMH Manual for Preparation of PC 1026 and 1370 Court Reports 4. DMH PC 1026 Court Report Monitoring Form 5. ASH PC 1026 Court Report Monitoring summary data (September 2007 to February 2008) 6. DMH PC 1370 Court Report Monitoring Form 7. ASH PC 1370 Court Report Monitoring summary data (September 2007 to February 2008) 8. Minutes of the Forensic Review Panel during this reporting period (September 2007 to February 2008)
D.7.a	Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals adjudicated "not guilty by reason of insanity" ("NGI") pursuant to Penal Code Section 1026, based on accurate information, and individualized risk assessments. The forensic reports should include the following, as clinically indicated:	**Compliance:** Substantial; however, continued compliance will require ongoing vigilance in satisfying all the requirements in this section, including D.7.a.i.

D.7.a.i	clinical progress and achievement of stabilization of signs and symptoms of mental illness that were the cause, or contributing factor in the commission of the crime (i.e., instant offense);	**Current findings on previous recommendation:** **Recommendation, October 2007:** Continue to monitor 100% of PC 1026 reports and address any significant discrepancy between the facility's data and findings by this monitor. **Findings:** ASH has implemented a format for 1026 reports that aligns with the requirements in D.7.a. The facility used the DMH Court Report PC 1026 Monitoring Form to assess compliance (September 2007 to February 2008). The facility reviewed 100% of the court reports. The mean compliance rate was 86%. The compliance rate (100%) reported in the last review was based on two legal sub-categories of PC 1026 (1026.2 and 1026.5), but the current rate (86%) was based on all three sub-categories (1026f, 1026.2 and 1026.5). The data showed that with few exceptions (D.7.a.i), the compliance rates have improved compared to the last review. Regarding D.7.a.i, a breakdown of the data showed steady improvement in compliance since October 2007. The mean compliance rates for the requirements in D7.a.ii through D7.a.xi are reported for each corresponding cell below. The indicators are listed if they represented sub-criteria of the requirement. **Other findings:** This monitor reviewed the charts of six individuals who were admitted under PC 1026. The review found compliance in four charts (AFJ, CG, JN and PR) and noncompliance in two (PP and RB).

		Although overall compliance with D.7.a is substantial, the facility needs to make further progress in this requirement to ensure that symptoms contributing to the offense and persisting during hospitalization are better specified regarding their nature, course and setting within which they occur. **Current recommendations**: 1. Continue to monitor this requirement and provide data analysis that evaluates decrease in compliance and delineates relative improvement (during the reporting period and compared to the past period), as indicated. 2. Ensure that symptoms contributing to the offense and persisting during hospitalization are better specified regarding their nature, course and setting within which they occur.
D.7.a.ii	acts of both verbal and physical aggression and property destruction during the past year of hospitalization and, if relevant, past acts of aggression and dangerous criminal behavior;	**Current findings on previous recommendation:** **Recommendation, October 2007:** Same as above. **Findings:** Compliance: 96%. **Other findings:** Reviewing the above-mentioned six charts, this monitor found compliance in all cases. **Current recommendations**: Continue to monitor this requirement and provide data analysis that evaluates decrease in compliance and delineates relative improvement (during the reporting period and compared to the past period), as indicated.

<table>
<tr>
<td>D.7.a.iii</td>
<td>understanding of potential for danger and precursors of dangerous/criminal behavior, including instant offense;</td>
<td>Current findings on previous recommendation:

Recommendation, October 2007:
Same as above.

Findings:
Compliance: 87%.

Other findings:
This monitor found compliance in four charts (EFJ, JN, PP and RB), partial compliance in one (CG) and noncompliance in one (PR).

Although overall compliance with D.7.a is substantial, the facility needs to make further progress in this requirement to ensure that the clinical assessment does not rest on the individual's acknowledgment of dangerous behavior, but also includes his interpretation of the behavior and of the precipitating factors.

Current recommendations:
Same as above.</td>
</tr>
<tr>
<td>D.7.a.iv</td>
<td>acceptance of mental illness and understanding of the need
for treatment, both psychosocial and biological, and the need to adhere to treatment;</td>
<td>Current findings on previous recommendation:

Recommendation, October 2007:
Same as above.

Findings:

<table>
<tr><td>1.</td><td>Individual's acceptance of mental illness</td><td>95%</td></tr>
<tr><td>2.</td><td>Individual's understanding of the need for treatment</td><td>95%</td></tr>
<tr><td>3.</td><td>Individual's adherence to treatment</td><td>97%</td></tr>
</table>
</td>
</tr>
</table>

<table>
<tr><td></td><td></td><td>Other findings:
This monitor found compliance in four charts (CG, JN, PP and PR) and partial compliance in two (EFJ and RB).

Current recommendations:
Same as above.</td></tr>
<tr><td>D.7.a.v</td><td>development of relapse prevention plan (i.e., Personal Wellness Recovery Plan or Wellness Recovery Action Plan) for mental illness symptoms, including the individual's recognition of precursors and warning signs and symptoms and precursors for dangerous acts;</td><td>Current findings on previous recommendation:

Recommendation, October 2007:
Same as above.

Findings:

<table><tr><td>1.</td><td>Individual's development of relapse prevention plan for mental illness symptoms</td><td>89%</td></tr><tr><td>2.</td><td>Individual's recognition of precursors and warning signs and symptoms (that may mediate) future dangerous acts</td><td>86%</td></tr></table>
Other findings:
This monitor found compliance in all six charts reviewed.

Current recommendations:
Same as above.</td></tr>
<tr><td>D.7.a.vi</td><td>willingness to achieve understanding of substance abuse
issues and to develop an effective relapse prevention plan (as defined above);</td><td>Current findings on previous recommendation:

Recommendation, October 2007:
Same as above.

Findings:
Compliance: 91%.</td></tr>
</table>

		Other findings: Reviews by this monitor of the above-mentioned charts found compliance in all cases. **Current recommendations**: Same as above.
D.7.a.vii	previous community releases, if the individual has had previous CONREP revocations;	**Current findings on previous recommendation:** **Recommendation, October 2007:** Same as above. **Findings:** Compliance: 86%. **Other findings:** Chart reviews by this monitor found compliance in all relevant cases (JN, PP and RB). **Current recommendations**: Same as above.
D.7.a. viii	social support, financial resources, family conflicts, cultural marginalization, and history of sexual and emotional abuse, if applicable; and	**Current findings on previous recommendation:** **Recommendation, October 2007:** Same as above. **Findings:** Compliance: 85%. **Other findings:** This monitor found compliance in two charts (JN and PP) and partial compliance in four (CG, EFJ, PR and RB).

		Current recommendations: Same as above.
D.7.a.ix	relevant medical issues, all self-harm behaviors, risks for self harm and risk of harm to others, to inform the courts and the facility where the individual will be housed after discharge.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Same as above. **Findings:** Compliance: 77%. **Other findings:** This monitor found compliance in four charts (CG, JN, PP and PB) and partial compliance in two (EFJ and PR). **Current recommendations**: Same as above.
D.7.b	Each State hospital shall develop and implement policies and procedures to ensure an interdisciplinary approach to the development of court submissions for individuals admitted to the hospital pursuant to Penal Code Section 1370, "incompetent to stand trial" ("IST"), based on accurate information and individualized risk assessments. Consistent with the right of an individual accused of a crime to a speedy trial, the focus of the IST hospitalization shall be the stabilization of the symptoms of mental illness so as to enable the individual to understand the legal proceedings and to assist his or her attorney in the preparation of the defense. The forensic reports should include the following:	**Compliance:** Substantial.

D.7.b.i	relevant clinical description of initial presentation, if available, which caused the individual to be deemed incompetent to stand trial by the court;	**Current findings on previous recommendations:** **Recommendations 1 and 2 October 2007:** • Continue to monitor 100% of PC 1370 reports. • Continue current progress in the format and quality of PC 1370 reports. **Findings:** ASH used the DMH Court Report PC 1370 Monitoring Form to assess compliance (September 2007 to February 2008). The facility reviewed 100% of the court reports. The mean compliance rate was 93%. In general, the data showed improved compliance compared to the last review. The mean compliance rates for the requirements in D7.b.ii through D7.b.iv are reported for each corresponding cell below. The indicators are listed if they represented sub-criteria of the requirement. **Other findings:** This monitor reviewed the charts of six individuals who were admitted under PC 1370 (AR, CCB, DC, RC, RS and TS). The review found compliance in all cases. **Current recommendations**: Continue to monitor this requirement and provide data analysis that evaluates decrease in compliance and delineates relative improvement (during the reporting period and compared to the past period), as indicated.
D.7.b.ii	clinical description of the individual at the time of admission to the hospital;	**Current findings on previous recommendation:** **Recommendation, October 2007:** Same as above

<table>
<tr><td></td><td></td><td>Findings:
Compliance: 99%.

Other findings:
This monitor found compliance in five charts (AR, DC, RC, RS and TS) and partial compliance in one (CCB).

Current recommendations:
Same as above.</td></tr>
<tr><td>D.7.b.iii</td><td>course of hospital stay, describing any progress or lack of progress, response to treatment, current relevant mental status, and reasoning to support the recommendation; and</td><td>Current findings on previous recommendation:

Recommendation, October 2007:
Same as above.

Findings:

<table>
<tr><td>1.</td><td>Description of any progress or lack of progress</td><td>100%</td></tr>
<tr><td>2.</td><td>Individual's response to treatment</td><td>88%</td></tr>
<tr><td>3.</td><td>Current relevant mental status</td><td>87%</td></tr>
<tr><td>4.</td><td>Reasoning to support the recommendation: a) stability of the symptom and capacity to cooperate rationally with counsel in the conduct of a defense; b) individual's understanding of the charge and legal procedures</td><td>85%</td></tr>
</table>
Other findings:
This monitor found compliance in five charts (AR, CCB, DC, RC and RS) and partial compliance in one (TS).

Current recommendations:
Same as above.</td></tr>
</table>

D.7.b.iv	all self-harm behaviors and relevant medical issues, to inform the courts and the facility where the individual will be housed after discharge.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Same as above. **Findings:** Compliance: 93%. **Other findings:** This found compliance in all six charts reviewed. **Current recommendations**: Same as above.
D.7.c	Each State hospital shall establish a Forensic Review Panel (FRP) to serve as the internal body that reviews and provides oversight of facility practices and procedures regarding the forensic status of all individuals admitted pursuant to Penal Code 1026 and 1370. The FRP shall review and approve all forensic court submissions by the Wellness and Recovery Teams and ensure that individuals receive timely and adequate assessments by the teams to evaluate changes in their psychiatric condition, behavior and/or risk factors that may warrant modifications in their forensic status and/or level of restriction.	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Continue current practice regarding reviews by the FRP and oversight by the Medical Director. **Findings:** ASH has maintained its practice of reviewing of 100% of court reports and providing feedback by the FRP and its Chair as well as oversight by the Medical Director. **Recommendation 2, October 2007:** Standardize monitoring indicators (PCs 1026 and 1370) for use across all four facilities and develop instructions for each indicator. **Findings:** The DMH has implemented this recommendation.

		Compliance: Substantial. **Current recommendations**: Continue current practice.
D.7.c.i	The membership of the FRP shall include Director of Forensic Psychiatry, Facility Director or designee, Medical Director or designee, Chief of Psychology or designee, Chief of Social Services or designee, Chief of Nursing Services or designee, and Chief of Rehabilitation Services or designee. The Director of Forensic Psychiatry shall serve as the chair and shall be a board certified forensic psychiatrist. A quorum shall consist of a minimum of four FRP members or their designee.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Ensure that all members of the FRP, including psychiatry and psychology, have completed adequate training in forensic procedures. **Findings:** ASH reported that the psychologist and psychiatrist members of the FRP receive ongoing training on forensic report writing on a weekly basis in the forensic services meeting at the facility. These members regularly author the forensic reports. Other members of the FRP receive instruction during the PRP meeting. The facility did not provide further specifics regarding this recommendation. **Compliance:** Partial. **Recommendations:** Provide specifics regarding the forensic training provided to all members of the PRP by ASH and/or other authorities. Indicate if members have received any training other than through staff meetings and discussions at ASH.

E. Discharge Planning and Community Integration		
		Summary of Progress: Significant opportunities remain to improve practices related to discharge planning at ASH.
E	Taking into account the limitations of court-imposed confinement, the State shall pursue actively the appropriate discharge of individuals under the State's care at each State hospital and, subject to legal limitations on the state's control of the placement process, provide services in the most integrated, appropriate setting in which they reasonably can be accommodated, as clinically appropriate, that is consistent with each individual's needs.	**Methodology:** Interviewed: 1. Alice Dodge, LCSW, Social Work 2. Donna Nelson, Standards Compliance Director 3. Janet Bouffard, LCSW, Chief of Social Work 4. Jeannine Doolin, RN, Quality Assurance Monitor 5. John De Morales, Executive Director 6. Sherie Colleen, LCSW, Social Work Reviewed: 1. Charts of the following 37 individuals: ADG, AH, BRD, CM, DB, DJB, DY, EEO, EO, FB, FE, FR, JBW, JIL, JLW, JS, JW, KEL, LGT, LT, LW, MDW, MG, MM, MR, MRM, MW, RC, REZ, RT, RW, SRB, SW, TLC, TY, WM and WTM 2. CONREP Referrals (October 10, 2007 – April 1, 2008) 3. Current CONREP Referral Status (April 8, 2008) 4. EPPI Team Progress Report 5. Individual's family therapy survey (This document had a Spanish version) 6. List of individuals assessed to need family education 7. List of individuals who met discharge criteria and are still hospitalized 8. List of individuals who met discharge criteria in the last six months 9. List of individuals with cognitive disorders 10. List of individuals with substance abuse disorders 11. Therapeutic Milieu Outcome Measure

		12. DMH discharge Planning and Community Integration Auditing form 13. The Same Page Newsletter (Volume III) <u>Observed</u>: 1. WRPC for CM, Program III, Unit 21 2. WRPC for MG, Program IV, Unit 9A 3. Mall group: Depression and Crisis Management 4. Mall group: Symptom Management 5. Mall group: Coping with Anxiety 6. Mall group: "Ready-Set-Go" 7. Mall group: Substance Abuse Recovery 8. Mall group: Social Skills Through Music
E.1	Each State hospital shall identify at the 7-day therapeutic and rehabilitation service planning conference, and address at all subsequent planning conferences, the particular considerations for each individual bearing on discharge, including:	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Achieve continuity of the discharge process from admission to discharge through the WRP and WRPT process. **Findings:** This monitor reviewed 13 charts (ADG, AH, DJB, EO, FE, FR, JIL, JW, LT, LW, RT, SRB and WM). Two of the WRPs in the charts (DJB and FR) showed some level of continuity across WRPTs with assessment data and service provision meeting the individual's needs. The remaining 11 did not show continuity in the case formulation, service provision and discharge needs. For example, life goals did not have a foci (KW), case formulation was not comprehensive, skills and supports individuals needed or lacked were not identified and addressed through services (AH, EO, RT, SRB and WM). **Recommendation 2, October 2007:** Involve the individual in the discharge process through discussion of discharge criteria and how to meet them by attending relevant PSR

		mall groups, individual therapy (as needed), and by practicing newly acquired skills in the therapeutic milieu. **Findings:** This monitor reviewed 11 charts (ADG, AH, DJB, FE, JIL, LT, LW, MR, RT, SRB and WM). None of the 11 WRPs in the charts contained documentation in the Present Status section of the WRP that the individual was a participant in the discussion on discharge criteria and how to meet the criteria through participation in the PSR Mall groups, individual therapy (if needed) and by practicing newly acquired skills in the therapeutic milieu. This monitor attended two WRPCs (CM and MG). One team did not have a social worker to give an update on the individual's discharge status. In both teams, the individuals refused to participate in the team conference, thus the teams did not have the opportunity to address this issue with the individuals. **Recommendation 3, October 2007:** Social workers must review discharge status with the WRPT and the individual at all scheduled WRPCs involving the individual. **Findings:** This monitor reviewed 12 charts (ADG, AH, DJB, EO, FE, JIL, LT, LW, MR, RT, SRB and WM). Two of the WRPs in the charts (MR and SRB) contained documentation in the Present Status section of the WRP that Social Workers had reviewed the discharge status with the WRPT and the individual. The remaining ten (ADG, AH, DJB, EO, FE, JIL, LT, LW, RT and WM) did not have such documentation. **Recommendation 4, October 2007:** Continue to train staff on this requirement.

		Findings: Interview with the Social Work Chief and documentation review found that the Statewide monitoring tool was approved and implemented in ASH on October 2007. According to the Chief of Social Work, training in the last six months was minimal due to the lack of Supervising Social Workers. Furthermore, inter-rater reliability between monitors is yet to be established. **Compliance:** Partial. **Current recommendations:** 1. Achieve continuity of the discharge process from admission to discharge through the WRP and WRPT process. 2. Involve the individual in the discharge process through discussion of discharge criteria and how to meet them by attending relevant PSR mall groups, individual therapy (as needed), and by practicing newly acquired skills in the therapeutic milieu. 3. Social workers must review discharge status with the WRPT and the individual at all scheduled WRPCs involving the individual. 4. Continue to train staff on this requirement.
E.1.a	those factors that likely would foster successful discharge, including the individual's strengths, preferences, and personal life goals;	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Ensure that the individual's strengths and preferences are utilized to achieve discharge goals. These should be linked to the interventions that impact the individual's discharge criteria. **Findings:** ASH audited Program IV charts using item #1 from the DMH Discharge Planning and Community Integration Auditing Form (*Those factors that likely would foster successful discharge, including the*

individual's strengths, preferences, and personal life goals) to address this recommendation, reporting 64% compliance. The table below showing the number of WPRs due each month (N), the number of WRPs reviewed each month (n), the percentage of compliance obtained (%C) is a summary of the facility's data.

	Oct	Nov	Dec	Jan	Feb	Mean
N	44	66	45	49	65	
n	16	40	34	41	51	
%S	36	61	76	84	78	
%C #1	69	75	41	66	67	64

This monitor reviewed 20 charts (ADG, AH, DJB, DY, EO, JBW, JIL, JLW, LT, LW, MDW, MM, MR, MRM, MW, RW, SRB, SW, TY and WTM). Seven of the WRPs in the chart (DJB, DY, JBW, JLW, MRM, RW and TY) had utilized the individual's strengths, preferences, and life goals, and these were aligned with the intervention(s) that impacted the individual's discharge goals. The remaining 13 (ADG, AH, EO, JIL, LT, LW, MDW, MM, MR, MW, SRB, SW and WTM) did not.

Recommendation 2, October 2007:
The individual's life goals should be linked to one or more foci of hospitalization, with associated objectives and interventions.

Findings:
This monitor reviewed 12 charts (ADG, AH, DJB, EEO, FB, JIL, LT, LW, MR, RT, SRB and WTM). Four of the WRPs in the charts (DJB, EEO, LT and MR) had linked the individuals' life goals to one or foci of the individual's hospitalization, with associated objectives and integrations. The remaining eight (ADG, AH, FB, JIL, LW, RT, SRB, and WTM) did not.

		Compliance: Partial. **Current recommendations**: 1. Ensure that the individual's strengths and preferences are utilized to achieve discharge goals. These should be linked to the interventions that impact the individual's discharge criteria. 2. The individual's life goals should be linked to one or more foci of hospitalization, with associated objectives and interventions.
E.1.b	the individual's level of psychosocial functioning;	**Current findings on previous recommendations:** **Recommendations 1-3, October 2007:** • Ensure that the level of psychosocial functioning (functional status) is included in the individual's present status section of the case formulation section of the WRP. • Use the DMH WRP Manual in developing and updating the case formulation. • Ensure that team members are aware of and trained in elements to consider in updating GAF scores. This monitor reviewed 10 charts (DY, JBW, JLW, MDW, MM, MRM, MW, RW, SW and TY). Five of the WRPs in the charts (DY, JBW, MDW, MM and RW,) included the individuals' psychosocial functioning in the Present Status section. The remaining five (JLW, MRM, MW, SW and TY) did not include the information or the information was not comprehensive. According to the Chiefs of Social Work and Psychology, WRPTs have been trained in and are using the DMH WRP Manual to develop and update the case formulation. According to the Chief of Social Work, WRPT members have yet to

		receive training on GAF. As far as this monitor knows, each WRPT should have at least two staff members, psychologists and psychiatrists, with knowledge of GAF scores as part of their professional training. ASH may want to encourage peer teaching. **Compliance:** Partial. **Current recommendations:** 1. Ensure that the level of psychosocial functioning (functional status) is included in the individual's present status section of the case formulation section of the WRP. 2. Use the DMH WRP Manual in developing and updating the case formulation. 3. Ensure that team members are aware of and trained in elements to consider in updating GAF scores.
E.1.c	any barriers preventing the individual from transitioning to a more integrated environment, especially difficulties raised in previously unsuccessful placements; and	**Current findings on previous recommendations:** **Recommendations 1-3, October 2007:** • Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRPCs. • Include all skills training and supports in the WRP so that the individual can overcome barriers and meet discharge criteria. • Report to the WRPT, on a monthly basis, the individual's progress in overcoming the barriers to discharge. **Findings:** ASH audited Program IV charts using item #3 from the DMH Discharge Planning and Community Integration Auditing Form (*Any barriers preventing the individual from transitioning to a more integrated environment, especially difficulties raised in previously*

unsuccessful placements) to address this recommendation, reporting 2% compliance. The table below showing the number of WRPs due each month (N), the number of WRPs reviewed each month (n), the percentage of compliance obtained (%C) is a summary of the facility's data.

	Oct	Nov	Dec	Jan	Feb	Mean
N	44	66	45	49	65	
n	16	40	34	41	51	
%S	36	61	76	84	78	
%C #3	0	3	0	5	0	2

This monitor reviewed 11 charts (DY, JBW, JLW, LW, MDW, MM, MRM, MW, RW, SW and TY). Seven of the WRPs in the charts (DY, JBW, JLW, MM, MRM, RW and SW) contained documentation that the discharge barriers were discussed with the individual. The remaining four (LW, MDW, MW and TY) did not.

This monitor also reviewed 12 charts (ADG, AH, DB, EO, FE, JL, LT, LW, MR, RT, SRB and WTM). None of the WRPs in the charts included the skills training and supports the individual needed to overcome barriers to discharge.

Additionally, this monitor reviewed 10 charts (AH, DJB, EO, FE, JIL, LT, MR, RT, SRB and WM). Two of the WRPs in the charts (MR and SRB) contained documentation in the Present Status section of the WRP that Social Workers had reviewed the discharge status with the WRPTs and the individuals. The remaining eight (AH, DJB, EO, FE, JIL, LT, RT and WM) did not have documentation to show that the information was shared with the WRPT.

Compliance:
Partial.

<table>
<tr>
<td></td>
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<td>Current recommendations:
1. Ensure that discharge barriers, especially difficulties in previously unsuccessful placements, are discussed with the individual at scheduled WRPCs.
2. Include all skills training and supports in the WRP so that the individual can overcome barriers and meet discharge criteria.
3. Report to the WRPT, on a monthly basis, the individual's progress in overcoming the barriers to discharge.</td>
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<tr>
<td>E.1.d</td>
<td>the skills and supports necessary to live in the setting in which the individual will be placed.</td>
<td>Current findings on previous recommendations:

Recommendations 1 and 2, October 2007:
• Assess the skills and supports that will be needed by the individual for a successful transition to the identified setting.
• Ensure that WRPT members focus on these requirements and update the individual's WRP as necessary.

Findings:
ASH audited Program IV charts using item #4 from the DMH Discharge Planning and Community Integration Auditing Form (The skills and supports necessary to live in the setting in which the individual will be placed)to address this recommendation, reporting 28% compliance. The table below showing the number of WPRs due each month (N), the number of WRPs reviewed each month (n), the percentage of compliance obtained (%C) is a summary of the facility's data.

<table>
<tr><th></th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mean</th></tr>
<tr><td>N</td><td>44</td><td>66</td><td>45</td><td>49</td><td>65</td><td></td></tr>
<tr><td>n</td><td>16</td><td>40</td><td>34</td><td>41</td><td>51</td><td></td></tr>
<tr><td>%S</td><td>36</td><td>61</td><td>76</td><td>84</td><td>78</td><td></td></tr>
<tr><td>%C #4</td><td>13</td><td>30</td><td>38</td><td>37</td><td>16</td><td>28</td></tr>
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		This monitor reviewed 18 charts (ADG, AH, DB, EO, FE, JLW, LW, MDW, MM, MR, MRM, MW, RT, RW, SRB, SW, TY and WTM). Six of the WRPs in the charts (AH, DB, MM, MR, RW and SW) documented the skills and supports that is needed by the individual for a successful transition to the identified setting. The remaining 12 WRPs (ADG, EO, FE, JLW, LW, MDW, MRM, MW, RT, SRB, TY and WTM) did not contain such documentation. WRPT members need to update changes to the skills and supports as identified on an ongoing basis. **Compliance:** Partial. **Current recommendations**: 1. Assess the skills and supports that will be needed by the individual for a successful transition to the identified setting. 2. Ensure that WRPT members focus on these requirements and update the individual's WRP as necessary.
E.2	Each State hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process, to the fullest extent possible, given the individual's level of functioning and legal status.	**Current findings on previous recommendations:** **Recommendations 1 and 2, October 2007:** • Ensure that the individual is an active participant in the discharge planning process. • Implement the DMH WRP Manual on discharge process. **Findings:** ASH audited Program IV charts using item #12 from the DMH Discharge Planning and Community Integration Auditing Form (see below) to address this recommendation, reporting 5% compliance. The table below with its monitoring indicator showing the number of WPRs due each month (N), the number of WRPs reviewed each month (n), the percentage of compliance obtained (%C) is a summary of the facility's

data.

Each State hospital shall ensure that, beginning at the time of admission and continuously throughout the individual's stay, the individual is an active participant in the discharge planning process to the fullest extent possible, given the individual's level of functioning and legal status.

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
N	235	264	261	257	270	232	
n	137	116	163	147	193	137	
%S	57	44	62	57	71	59	
%C #12	2	1	1	4	7	12	5

This monitor's documentation review and interview with the Chief of Social Work found that ASH had conducted staff training on the DMH WRP Manual. ASH has trained 91% of the MDs, 96% of the PhDs, 90% of the Social Workers, 97% of the Rehabilitation Therapists, 59% of the Nurses, and 51% of the Physical Therapists on the DMH WRP Manual.

This monitor reviewed 11 charts (ADG, AH, EO, FE, JL, LT, LW, MR, RT, SRB and WTM). WRPs in five of the charts (ADG, E0, JL, LT and SRB) contained documentation indicating that the individual was an active participant in the discharge process. The remaining six (AH, FE, LW, MR, RT and WTM) did not contain such documentation.

Recommendation 3, October 2007:
Prioritize objectives and interventions related to the discharge processes.

Findings:
This monitor reviewed 11 charts (ADG, AH, DB, FE, JL, KEL, LGT, MR,

		RT, SRB and WTM). None of the 11 WRPs in the charts had a foci, relevant objectives, and appropriate interventions with relevant PSR Mall group/individual therapy for each discharge criteria for each individual. **Recommendation 4, October 2007:** Ensure that the individual understands all of the discharge requirements before leaving the WRPC. **Findings:** This monitor reviewed six charts (DB, FE, LW, MRM, RT and SRB). None of the six WRPs in the charts had documented evidence that each discharge criteria was discussed with the individual and if the individual understood his/her discharge status. **Compliance:** Partial. **Current recommendations**: 1. Ensure that the individual is an active participant in the discharge planning process. 2. Implement the DMH WRP Manual on discharge process. 3. Prioritize objectives and interventions related to the discharge processes. 4. Ensure that the individual understands all of the discharge requirements before leaving the WRPC.
E.3	Each State hospital shall ensure that, consistent with generally accepted professional standards of care, each individual has a professionally developed discharge plan that is integrated within the individual's therapeutic and rehabilitation service plan, that addresses his or her particular discharge	**Current findings on previous recommendation:** **Recommendation, October 2007:** Follow the established DMH WRP process for discharge planning to ensure that each individual has a professionally developed discharge plan that is integrated within the individual's WRP and Psychosocial

	considerations, and that includes:	Rehabilitation Services. **Findings:** This monitor reviewed ten charts (ADG, AH, DB, FE, JL, LT, LW, MR, SRB and WTM). None of the WRPs in these charts followed the DMH WRP process for discharge planning to meet all required elements in the foci, the objectives, the interventions, and the PSR Mall services. Similarly, an overview of the data obtained from sections C.2, D.2, D.6, E, and F.2 showed that many elements related to discharge in WRPs, WRPC's, and PSR Mall services are weak. This monitor's findings align with ASH's progress report. **Compliance:** Noncompliance. **Current recommendations**: Follow the established DMH WRP process for discharge planning to ensure that each individual has a professionally developed discharge plan that is integrated within the individual's WRP and Psychosocial Rehabilitation Services.
E.3.a	measurable interventions regarding these discharge considerations;	**Current findings on previous recommendation:** **Recommendation, October 2007:** Write all interventions, including those dealing with discharge criteria, in behavioral and measurable terms as outlined in the DMH WRP Manual. **Findings:** ASH audited Program IV charts using item #12 from the DMH Discharge Planning and Community Integration Auditing Form (*Measurable interventions regarding these discharge considerations*) to address this recommendation, reporting 47% compliance. The table

<table>
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<td>below showing the number of WPRs due each month (N), the number of WRPs reviewed each month (n), the percentage of compliance obtained (%C) is a summary of the facility's data.

<table>
<tr><td></td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean</td></tr>
<tr><td>N</td><td>44</td><td>66</td><td>45</td><td>49</td><td>65</td><td></td></tr>
<tr><td>n</td><td>16</td><td>40</td><td>34</td><td>41</td><td>51</td><td></td></tr>
<tr><td>%S</td><td>36</td><td>61</td><td>76</td><td>84</td><td>78</td><td></td></tr>
<tr><td>%C #6</td><td>81</td><td>35</td><td>56</td><td>66</td><td>24</td><td>47</td></tr>
</table>

This monitor reviewed seven charts (DB, EO, JIL, LW, MR, RT and SRB). Four of the WRPs in the charts (DB, JIL, RT and SRB) had the interventions written in behavioral and/or measurable terms, and the remaining three (EO, LW and MR) did not have the interventions written in observable and/or measurable terms.

Compliance:
Partial.

Current recommendation:
Write all interventions, including those dealing with discharge criteria, in behavioral and measurable terms as outlined in the DMH WRP Manual.</td>
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<tr>
<td>E.3.b</td>
<td>the staff responsible for implement the interventions; and</td>
<td>Current findings on previous recommendations:

Recommendation 1, October 2007:
Ensure that for each intervention, responsible staff members are clearly stated in the individual's WRP.

Findings:
ASH audited Program IV charts using item #12 from the DMH Discharge Planning and Community Integration Auditing Form (The</td>
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</table>

staff responsible for implementing the interventions is identified) to address this recommendation, reporting 47% compliance. The table below showing the number of WPRs due each month (N), the number of WRPs reviewed each month (n), the percentage of compliance obtained (%C) is a summary of the facility's data.

	Oct	Nov	Dec	Jan	Feb	Mean
N	44	66	45	49	65	
n	16	40	34	41	51	
%S	36	61	76	84	78	
%C #7	63	75	62	75	47	64

This monitor reviewed seven charts (DB, EO, FE, JIL, MR, RT and SRB). Four of the WRPs in the charts (DB, EO, MR and RT) identified the staff member responsible for the interventions, and three of them (FE, JIL and SRB) did not do so for one or more of the interventions.

Recommendation 2, October 2007:
Confirm that the staff to be listed in the WRP is actually involved in facilitating the activity, group, or intervention.

Findings:
This monitor reviewed seven charts (CM, JS, LW, MG, MM, MR and RT), and compared the information in the interventions sections of the WRPs against the individuals' Mall schedules. Six of the WRPs in the charts (CM, JS, LW, MG, MR and RT) had the correct facilitators as listed in the individuals' activity schedules and one of them (MM) did not.

Compliance:
Partial.

<table>
<tr><td></td><td></td><td>Current recommendations:
1. Ensure that for each intervention, responsible staff members are clearly stated in the individual's WRP.
2. Confirm that the staff to be listed in the WRP is actually involved in facilitating the activity, group, or intervention.</td></tr>
<tr><td>E.3.c</td><td>The time frames for completion of the interventions.</td><td>Current findings on previous recommendation:

Recommendation, October 2007:
For each intervention in the Mall or for individual therapy, clearly State the time frame for the next scheduled review. This review should be the same as the individual's scheduled WRPC.

Findings:
ASH audited Program IV charts using item #8 from the DMH Discharge Planning and Community Integration Auditing Form (The time frames for completion of the interventions)to address this recommendation, reporting 47% compliance. The table below showing the number of WPRs due each month (N), the number of WRPs reviewed each month (n), the percentage of compliance obtained (%C) is a summary of the facility's data

<table>
<tr><td></td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mean</td></tr>
<tr><td>N</td><td>44</td><td>66</td><td>45</td><td>49</td><td>65</td><td></td></tr>
<tr><td>n</td><td>16</td><td>40</td><td>34</td><td>41</td><td>51</td><td></td></tr>
<tr><td>%S</td><td>36</td><td>61</td><td>76</td><td>84</td><td>78</td><td></td></tr>
<tr><td>%C #8</td><td>75</td><td>13</td><td>41</td><td>63</td><td>57</td><td>47</td></tr>
</table>

This monitor reviewed seven charts (DB, FE, JIL, LW, MR, RT and SRB). Four of the WRPS in the charts (DB, LW, RT and SRB) had a clearly stated timeframe for the next scheduled review for each intervention in the Mall or for individual therapy. Three of them (FE, JIL and MR) did not have a timeframe or had an incorrect timeframe</td></tr>
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		for the next review schedule. **Compliance:** Partial. **Current recommendation:** For each intervention in the Mall or for individual therapy, clearly State the time frame for the next scheduled review. This review should be the same as the individual's scheduled WRPC.
E.4	Each State hospital shall provide transition supports and services consistent with generally accepted professional standards of care. In particular, each State hospital shall ensure that:	**Compliance:** Partial.
E.4.a	individuals who have met discharge criteria are discharged expeditiously, subject to the availability of suitable placements; and	**Current findings on previous recommendations:** **Recommendation 1-4, October 2007:** • Reduce the overall number of individuals still hospitalized after referral for discharge has been made. • Identify and resolve system factors that act as barriers to timely discharge. • Develop and implement a tracking and monitoring system for obtaining data on all individuals delayed from their discharge. • Ensure that reasons for admission, previous admissions, and potential discharge settings are taken into account when setting discharge criteria. **Findings:** This monitor's documentation review found that ASH has established a database for tracking and monitoring individuals referred for discharge. The table below showing the number of individuals still in hospital by the length of stay pass the date of referral is a summary of the facility's data.

<table>
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<tr><th>CONREP referrals pending d/c</th><th>Under 60 days</th><th>60-120 Days</th><th>120–180 days</th><th>180-240 days</th><th>Over 240 days</th></tr>
<tr><td>10</td><td>6</td><td>2</td><td>1</td><td>0</td><td>1</td></tr>
</table>

According to the Chief of Social Work CONREP bed availability continues to be a major barrier to expeditious discharge of individuals referred for discharge.

Recommendation 5, October 2007:
Write all discharge criteria in behavioral terms.

Findings:
This monitor reviewed six charts (BRD, MG, RC, REZ, SRB and TLC). Two of the WRPs in the charts (RC and TLC) contained discharge criteria written in behavioral terms, and the remaining four (BRD, MG, REZ and SRB) contained one or more of the discharge criteria written in non-behavioral/measurable terms.

Current recommendations:
1. Reduce the overall number of individuals still hospitalized after referral for discharge has been made.
2. Identify and resolve system factors that act as barriers to timely discharge.
3. Write all discharge criteria in behavioral terms.
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<tr>
<td>E.4.b</td>
<td>Individuals receive adequate assistance in transitioning to the new setting.</td>
<td>
Current findings on previous recommendations:

Recommendations 1 and 2, October 2007:
• Develop and implement a monitoring and tracking system to address the key elements of this requirement.
• Ensure and document specific assistance provided to the individual
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and/or appropriate others when the individual is transitioned to a new setting.

Findings:
ASH audited Program IV charts using item #10 from the DMH Discharge Planning and Community Integration Auditing Form (*Individuals receive adequate assistance in transitioning to the new setting*) to address this recommendation, reporting 2% compliance. The table below showing the number of WPRs due each month (N), the number of WRPs reviewed each month (n), the percentage of compliance obtained (%C) is a summary of the facility's data

	Oct	Nov	Dec	Jan	Feb	Mean
N	44	66	45	49	65	
n	16	40	34	41	51	
%S	36	61	76	84	78	
%C #10	0	0	3	2	2	2

According to the Chief of Social Work, a system has not been put in place to monitor and track the elements of this EP requirement. She has plans to train Social Workers on this requirement, to review monthly auditing data for compliance on an ongoing basis and to give feedback to the Social Workers so that this requirement is addressed.

This monitor reviewed eight charts (DB, EO, FE, JIL, LW, MR, RT and SRB). One of the WPRs in the charts (MR) had documented evidence that the assistance needed by the individual in the new setting was identified and provided to the individual, and the remaining seven (DB, EO, FE, JIL, LW, RT and SRB) did not.

Current recommendations:
1. Develop and implement a monitoring and tracking system to address the key elements of this requirement.

		2. Ensure and document specific assistance provided to the individual and/or appropriate others when the individual is transitioned to a new setting.
E.5	For all children and adolescents it serves, each State hospital shall:	The requirements of Section E.5 are not applicable to ASH because it does not serve children or adolescents.
E.5.a	develop and implement policies and protocols that identify individuals with lengths of stay exceeding six months; and	
E.5.b	establish a regular review forum, which includes senior administration staff, to assess the children and adolescents identified in § V.E.1 above, to review their treatment plans, and to create an individualized action plan for each such child or adolescent that addresses the obstacles to successful discharge to the most integrated, appropriate placement as clinically and legally indicated.	

F. Specific Therapeutic and Rehabilitation Services	
	Summary of Progress on Psychiatric Services: 1. ASH has developed and implemented a procedure to ensure a time limit of 14 days regarding PRN medication orders. 2. ASH has implemented the new DMH standardized tools to monitor its use of benzodiazepines, anticholinergics and polypharmacy. 3. ASH has developed adequate tools for the reporting of adverse drug reactions and medication variances. 4. ASH has improved the process of Intensive Case Analysis of Adverse Drug Reactions. 5. ASH has established a Medication Management EP Performance Improvement Committee. **Summary of Progress on Psychological Services:** 1. ASH has completed its review of all 590 Integrated Assessments: Psychology Section of individuals admitted before June 1, 2006. 2. ASH has completed all Integrated Psychological Assessments of individuals in the admission units. 3. ASH has significantly increased the number of behavioral guidelines developed and implemented for individuals exhibiting learned maladaptive behaviors. **Summary of Progress on Nursing Services:** 1. Nursing has revised a number of its policies and procedures in alignment with the EP and Wellness and Recovery. 2. As of January 2008, ASH has initiated hospital-wide monitoring for the medication competency observations. **Summary of Progress on Rehabilitation Therapy Services:** 1. Course Outlines and Lesson Plans have been initiated for some Rehabilitation Therapy PSR Mall groups, and include groups for various foci, using Rehabilitation Therapy modalities. However,

	groups for Focus 10 continue to lack formal Lesson Plans and curricula. 2. F4 Monitoring tool is pending development and implementation. No facility audit data has been provided for F4 EP cells. **Summary of Progress on Nutrition Services:** 1. The Meal Accuracy Report has been implemented and review of data shows substantial compliance with tray accuracy. 2. PSR Mall Lesson Plans have been developed and appear to meet Enhancement plan requirements. **Summary of Progress on Pharmacy Services:** ASH has achieved substantial compliance with the requirement regarding physicians' consideration of pharmacists' recommendations that address new orders. **Summary of Progress on General Medical Services:** 1. ASH has developed draft revisions of its Medical Care Policies and Procedures to address the deficiencies reported by the CM. 2. ASH has maintained compliance with the requirement regarding after-hours coverage by Psychiatric and Medical Officers-of-the-Day. 3. ASH has provided adequate analysis of its self-evaluation data regarding care of specific medical conditions. 4. ASH has established a Medical Services EP Performance Improvement Team. **Summary of Progress on Infection Control:** 1. The Infection Control Department has begun to integrate its compliance data into the Infection Control Committee Meetings and the Performance Improvement Committee Meetings 2. The Infection Control Department has audited more than 20% samples.

	Summary of Progress on Dental Services 1. There have been no identified incidents of problematic issues related to after-hours dental emergencies since the implementation of ASH's new procedure addressing dental emergencies. 2. The statewide Dental Monitoring tool has been approved and will be implemented to generate data for the next review period. 3. Practices regarding extractions are in substantial compliance.

1. Psychiatric Services		
		Methodology: Interviewed: 1. Jean Dansereau, MD, Chief of Psychiatry 2. Stephen Mohaupt, MD, Chairman of the Medication Management EP Performance Improvement Committee 3. Donna Nelson, Director of Standards Compliance Reviewed: 1. The charts of the following 39 individuals: AA, AE, ALS, ARC, AS, BO, BWM, CDB, CDM, DJM, DRS, DWH, EDS, EF, GG, GP, JAB, JG, JGC, JHC, JJS, JLJ, JMW, KSC, LG, MEB, MLD, ODM, PD, PNC, RA, SMB, TBR, TLG, TLM, TLW, WCB, WDR and WJB 2. Current DMH Policies and Medication Guidelines (effective January 2007) 3. DMH Admission Psychiatric Assessment Auditing Form 4. DMH Admission Psychiatric Assessment Auditing Form Instructions 5. ASH Admission Psychiatric Assessment Auditing summary data (January and February 2008) 6. DMH Integrated Assessment: Psychiatry Section Auditing Form 7. DMH Integrated Assessment: Psychiatry Section Auditing Form Instructions 8. ASH Integrated Assessment: Psychiatry Section Auditing summary data (January and February 2008) 9. DMH Monthly Psychiatric Progress Notes Auditing Form 10. DMH Monthly Psychiatric Progress Notes Auditing Form Instructions 11. ASH Monthly Psychiatric Progress Notes Auditing summary data (January and February 2008) 12. DMH Benzodiazepine Auditing Form 13. DMH Benzodiazepine Auditing Form Instructions. 14. ASH Benzodiazepine Auditing summary data (January and February

		2008). 15. DMH Anticholinergic Auditing Form. 16. DMH Anticholinergic Auditing Form Instructions 17. ASH Anticholinergic Auditing summary data (January and February 2008) 18. DMH Polypharmacy Auditing Form 19. DMH Polypharmacy Auditing Form Instructions 20. ASH Anticholinergic Auditing summary data (January and February 2008) 21. ASH New Generation Antipsychotic Monitoring Form 22. ASH New Generation Antipsychotic Monitoring summary data (September 2007 to February 2008) 23. ASH Tardive Dyskinesia Database 24. DMH Tardive Dyskinesia (TD) Auditing Form 25. DMH TD Auditing Form Instructions 26. ASH TD Auditing summary data (January and February 2008) 27. ASH data regarding Adverse Drug Reactions (ADRs) and medication variances from September 2007 to February 2008 28. Last ten completed ADR reporting forms 29. ASH AD (Draft), ADR Reporting and Monitoring 30. ASH Guidelines (Draft) for Completing ADR Reporting and Monitoring Form 31. ASH Intensive case analyses (#6) for ADRs during this review period 32. ASH AD (Draft), Drug utilization Evaluation (DUE) Reporting and Monitoring 33. ASH Nursing Procedure #310.1, Medication Variances (February 25, 2008) 34. ASH AD (Draft), Medication Variances 35. Last ten completed medication variance reporting forms 36. Format of Intensive Case Analysis regarding medication variances 37. Meeting minutes of the Pharmacy and Therapeutics (P&T) Committee (September 2007 to February 2008)

F.1.a	Each State hospital shall develop and implement policies and procedures to ensure system-wide monitoring of the safety, efficacy, and appropriateness of all psychotropic medication use, consistent with generally accepted professional standards of care. In particular, policies and procedures shall require monitoring of the use of psychotropic medications to ensure that they are:	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Implement individualized medication guidelines that include specific information regarding indications, contraindications, clinical and laboratory monitoring and adverse effects for all psychotropic and anticonvulsant medications in the formulary. The guidelines must be derived from current literature, relevant clinical experience and current generally accepted professional practice guidelines. **Findings:** California DMH Psychotropic Medication Policies and Guidelines have been implemented statewide. Since the initial version of the guidelines was issued (March 2007), a statewide committee has implemented updates of these guidelines (June 2007). ASH has adopted the updated guidelines. These guidelines do not include the mood stabilizers lithium and carbamazepine and the antidepressants venlafaxine, buproprion and mirtazapine. **Recommendation 2, October 2007:** Continue to monitor this requirement and ensure that all indicators are specifically matched to the requirement. **Findings:** ASH used the new standardized DMH Admission Psychiatric Assessment, Integrated Assessment: Psychiatry and Monthly Physician Progress Note (PPN) Audit forms to assess compliance. (January and February 2008). The average sample sizes were 31%, 76% and 6% respectively. ASH recognized that analysis of the Monthly PPN monitoring is limited by the small sample size. In addition, the sample was not randomly selected (only charts that contained monthly progress notes were reviewed). In March 2008, the facility provided instructions to the senior (supervising) psychiatrists to monitor and

		review 20% of all individuals who have been hospitalized for at least 90 days, randomized by the attending psychiatrists. The compliance rates are presented for each sub-cell below. The monitoring indicators are listed if they represented subcomponents of the corresponding requirement. The facility has reportedly provided feedback related to data collection to the admission psychiatrists through the senior supervising psychiatrists for mentoring and quality improvement. Effective May 1, 2008, the Psychiatric Quality Profile (PQP) will reportedly provide feedback to the admitting psychiatrists on a monthly basis. In addition, ASH plans to implement a diagnosis review panel (May 1, 2008) to improve the quality of the diagnostic formulations. **Other findings:** The use of the DMH standardized tools has improved data gathering, presentation and alignment with each requirement in F.1.a. **Compliance:** Partial. **Current recommendations**: 1. Finalize individualized guidelines for psychotropic and anticonvul-sant medications listed in the formulary. 2. Ensure that the individualized medication guidelines are continually revised, as appropriate, to reflect current literature, relevant clinical experience and professional practice guidelines. 3. Monitor these requirements using the standardized DMH tools based on at least a 20% sample. 4. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period).

F.1.a.i	specifically matched to current, clinically justified diagnoses or clinical symptoms;	

Admission Psychiatric Assessment		
8.	*Plan of care includes the following:* • *Regular psychotropic medications with rationale;* • *PRN and/or Stat medication as applicable, with specific behavioral indications; and* • *Special precautions to address risk factors, as indicated.*	85%

Integrated Assessment (Psychiatry)		
7.	*Diagnostic formulation*	21%
10.	*Psychopharmacology plan includes:*	4%
	• *Current target symptoms*	100%
	• *Specific medications to be used*	100%
	• *Dosage titration schedules*	100%
	• *Adverse reactions to monitor*	4%
	• *Rationale for anticholinergics, benzodiazepines, polypharmacy and new generation anti-psychotics in an at-risk population*	49%
	• *Specific behavioral indications for PRN and Stat medications, if applicable*	46%
	• *Response to medications since admission, if applicable, including PRN and Stat medications.*	59%
	• *Medication consent issues were addressed*	96%

Monthly PPN		
2.b	*Identified target symptoms are documented*	73%
6.a.1	*The risks, benefits, and rationale for the current psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.*	44%
6.a.2	*There is a clear description of the reasoning for continuing the current medication regimen and the*	46%

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<tr><td></td><td>proposed future plans, such as augmentation, dose tapering, change in medication, etc.</td><td></td></tr>
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<tr><td>F.1.a.ii</td><td>prescribed in therapeutic amounts, as dictated by the needs of the individual served;</td><td>
<table>
<tr><td colspan="3">Monthly PPN</td></tr>
<tr><td>2.h</td><td>Relevant lab data and consults are documented.</td><td>60%</td></tr>
<tr><td>2.h.2</td><td>Current Psychotropic medication dosage/laboratory monitoring/diagnostic testing and consultation protocols are followed as indicated (as per DMH Psychotropic guidelines.)</td><td>70%</td></tr>
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<tr><td>F.1.a.iii</td><td>tailored to each individual’s symptoms;</td><td>Same as in F.1.a.i.</td></tr>
<tr><td>F.1.a.iv</td><td>monitored for effectiveness against clearly identified target variables and time frames;</td><td>
<table>
<tr><td colspan="3">Monthly PPN</td></tr>
<tr><td>2.b</td><td>Identified target symptoms are documented.</td><td>73%</td></tr>
<tr><td>2.c</td><td>Participation in treatment is documented.</td><td>63%</td></tr>
<tr><td>2.d</td><td>Progress towards objective in the Wellness and Recovery Plan.</td><td>41%</td></tr>
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<tr><td>F.1.a.v</td><td>monitored appropriately for side effects;</td><td>
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<tr><td colspan="3">Monthly PPN</td></tr>
<tr><td>6.b</td><td>Monitoring of side effects</td><td>58%</td></tr>
<tr><td>6.c</td><td>AIMS is completed</td><td>60%</td></tr>
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<tr><td>F.1.a.vi</td><td>modified based on clinical rationales;</td><td>
<table>
<tr><td colspan="3">Monthly PPN</td></tr>
<tr><td>6.a.</td><td>The risks, benefits, and rationale for the current</td><td>44%</td></tr>
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<tr><td>1</td><td>psychopharmacology plan including anticholinergics, benzodiazepines, and polypharmacy are documented.</td><td></td></tr>
<tr><td>6.a.2</td><td>There is a clear description of the reasoning for continuing the current medication regimen and the proposed future plans, such as augmentation, dose tapering, change in medication, etc.</td><td>46%</td></tr>
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<tr><td>F.1.a.vii</td><td>are not inhibiting individuals from meaningfully participating in treatment, rehabilitation, or enrichment and educational services as a result of excessive sedation; and</td><td>
<table>
<tr><td colspan="3">Monthly PPN</td></tr>
<tr><td>2.c</td><td>Participation in treatment is documented.</td><td>63%</td></tr>
<tr><td>6.b</td><td>Monitoring of side effects, including sedation.</td><td>58%</td></tr>
<tr><td>6.c</td><td>AIMS is completed</td><td>60%</td></tr>
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<tr><td>F.1.a.viii</td><td>Properly documented.</td><td>As requested by this monitor, the facility provided the following data regarding the weighted means for all items above.

<table>
<tr><td>Admission Psychiatric Assessment</td><td>85%</td></tr>
<tr><td>Integrated Assessment (Psychiatry)</td><td>12%</td></tr>
<tr><td>Monthly PPN</td><td>33%</td></tr>
</table>
</td></tr>
<tr><td>F.1.b</td><td>Each State hospital shall monitor the use of PRN and Stat medications to ensure that these medications are administered in a manner that is clinically justified and are not used as a substitute for appropriate long-term treatment of the individual's condition.</td><td>Current findings on previous recommendations:

Recommendations 1 and 2, October 2007:
• Consolidate the monitoring instruments regarding PRN and Stat medications, and report data that address EP requirements regarding each of the following:
o Psychiatric documentation of PRN medications' use.
o Psychiatric documentation Stat medications.</td></tr>
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- Nursing documentation of PRN medications' use.
- Nursing documentation of Stat medications' use.

- Monitor the use of PRN and Stat medications based on at least a 20% sample.

Findings:
The DMH has yet to develop a standardized tool to address the use of PRN and Stat medications. The facility used the DMH Monthly PPN Auditing Form to assess compliance (January and February 2008). The average sample was 21% of the individuals who have been hospitalized for at least 90 days. Compared to the last review period, the facility used more indicators that are relevant to this requirement. The indicators and corresponding mean compliance rates are as follows:

1.	*Timely review of the use of PRN ('pro re nata' or 'as needed) and 'Stat' (emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use:*	21%
a	*Describes the rationale/specific indications for all PRN orders*	38%
b	*Reviews (including circumstances of use and individual's response) of the PRNs and Stat medications used during the interval period.*	33%
c	*Discusses use of PRN/Stat as indicated to reduce the risk of restrictive interventions.*	17%
d	*Describes modification of regularly scheduled medication regimen based on the use of PRN/STAT medications.*	23%
e	*PRN medications are appropriately time limited, per policy*	No data

Recommendation 3, October 2007:
Provide ongoing feedback and mentoring by senior psychiatrists to

		ensure correction of the deficiencies noted by this monitor. **Findings:** ASH has yet to implement this recommendation. The senior (supervising) psychiatrists' positions were recently filled (March 24, 2008). **Recommendation 4, October 2007:** Implement a procedure to ensure that all PRN orders for psychotropic medications are limited to no more than 14 days of use before the orders are reviewed and rewritten as necessary. This time limit should be gradually shortened to three days of use. **Findings:** ASH has implemented this recommendation (February 2008). The facility reported that the Pharmacy Department has screened all psychiatric medication orders to ensure that they were limited to 14 days and the treatment units were notified when the PRN order did not comply with the new ASH PRN policy. **Other findings:** See D.1.f for this monitor's review of the appropriateness of PRN/Stat medication use. These reviews and other chart reviews by this monitor found that ASH has yet to make significant progress in correcting the deficiencies outlined in this and previous reports regarding the use of PRN and Stat medications. **Compliance:** Partial. **Current recommendations**: 1. Consolidate the monitoring instruments regarding PRN and Stat medications, and report data that address EP requirements

		regarding each of the following: a) Psychiatric documentation of PRN medications' use. b) Psychiatric documentation Stat medications. c) Nursing documentation of PRN medications' use. d) Nursing documentation of Stat medications' use. 2. Monitor the use of PRN and Stat medications based on at least a 20% sample. 3. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period). 4. Provide ongoing feedback and mentoring by senior psychiatrists to ensure correction of the deficiencies noted by this monitor.
F.1.c	Each State hospital shall monitor the psychiatric use of benzodiazepines, anticholinergics, and polypharmacy to ensure clinical justification and attention to associated risks.	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Standardize monitoring instruments regarding the use of benzodiazepines, anticholinergics and polypharmacy for use across facilities and ensure that these instruments are aligned with the DMH medication guidelines. **Findings:** ASH participated in a statewide forum in which the following tools were finalized: 1. DMH Benzodiazepine Audit Form; 2. DMH Benzodiazepine Audit Form Instructions; 3. DMH Anticholinergics Audit Form 4. DMH Anticholinergics Audit Form Instructions; 5. DMH Polypharmacy Audit Form; and 6. DMH Polypharmacy Audit Form Instructions The above tools have indicators and operational instructions that are

appropriate for use across facilities.

Recommendation 2, October 2007:
Monitor the use of benzodiazepines, anticholinergics and polypharmacy based on at least a 20% sample.

Findings:
ASH used the DMH Benzodiazepine (November 2007 to January 2008), Anticholinergics (September, October and December 2007 and January 2008) and Polypharmacy (October and November 2007 and January 2008) Audit Forms to assess compliance. The use of the standardized tools has resulted in some decrease in compliance ratings for some items, which was attributed to more stringent monitoring. The facility has instructed its senior psychiatrists to provide mentoring to improve overall compliance.

The following is a summary outline of the monitoring indicators and corresponding mean compliance rates:

Benzodiazepines
DMH Psychiatry Benzodiazepine Audit Form
(Average %S varied from 8 to 40% depending on the applicable indicator):

1.	*Indication for regularly scheduled use of Benzodiazepine, in accordance with the DMH Psychotropic Medication Guidelines, clearly documented in PPN*	45%
2.	*Benzodiazepine used for individuals with alcohol/drug use problems justified in PPN*	12%
3.	*Benzodiazepine used for individuals with cognitive disorders (borderline intellectual functioning, mental retardation, cognitive disorder NOS, dementia of any*	

			type) justified in PPN	
			Routine Benzodiazepine use for more than 2 months clearly document in PPN risks of:	
		4.	*Drug dependence*	16%
		5.	*Cognitive impairment*	10%
		6.	*Sedation*	19%
		7.	*Gait unsteadiness/falls, if indicated*	15%
		8.	*Respiratory depression (for those with underlying respiratory problems, e.g., COPD).*	0%
		9.	*Toxicity if used in individuals with liver impairment (if using long acting agents).*	6%
		10.	*Treatment modified in an appropriate and timely manner to ensure proper indications and minimize risk.*	42%
		Anticholinergics DMH Psychiatry Anticholinergic Audit Form (%S varied from 27 to 37% depending on the applicable indicator):		
		1.	*Indication for use of anticholinergic, in accordance with the DMH Psychotropic Medication Guidelines, clearly documented in PPN*	45%
		14.	*Dosage is within DMH Psychotropic Medication policy (unless TRC/MRC consult was obtained)*	99%
			Anticholinergic use in individuals (over 60) and/or individuals with cognitive disorders include documentation that address the risk of:	
		2.	*Cognitive impairment*	12%
		3.	*Sedation (if using antihistaminic, e.g., diphenhydramine*	14%
		4.	*Gait unsteadiness/falls as indicated*	14%
		5.	*Blurred vision, constipation, urinary retention*	11
		6.	*Worsening narrow angle glaucoma if present*	0%

			Anticholinergic use for more than 2 months, regardless of age or cognitive status, include documentation that address the risk of:	
		7.	*Cognitive impairment*	27%
		8.	*Sedation (if using antihistaminic, e.g., diphenhydramine*	21%
		9.	*Gait unsteadiness/falls (for individuals > 60 on antihistamine, e.g., diphenhydramine)*	21%
		10.	*Blurred vision, constipation, urinary retention*	11%
		11.	*Worsening narrow angle glaucoma if present*	0%
		12.	*Substance abuse/dependence if listed on Axis I (trihexyphenidyl or benztropine)*	7%
		13.	*Worsening TD if present*	0%
		15.	*Treatment modified in an appropriate and timely manner to ensure proper indications and minimize risk.*	24%

Inter-class Polypharmacy
DMH Psychiatry Interclass Polypharmacy Audit Form

For all individuals on inter- and intra-class polypharmacy (%S=11%):

1.	*There is documentation in the PPN of the target symptoms for each medication in accordance with the DMH Psychotropic Medication Guidelines*	31%
4.	*The PPN documents the risks of the polypharmacy including drug-to-drug interactions and cumulative side-effects*	5%

For all individuals on four or more drugs [inter-class polypharmacy] (%S=24%):

1.	*There is documentation in the PPN of the target*	31%

			symptoms for each medication in accordance with the DMH Psychotropic Medication Guidelines	
		2.	*The PPN justifies the need for interclass polypharmacy*	16%
		4.	*The PPN documents the risks of the polypharmacy including drug-to-drug interactions and cumulative side-effects*	5%

For all individuals on two or more drugs from the same class of drugs [intra-class polypharmacy] (%S=22%):

1.	*There is documentation in the PPN of the target symptoms for each medication in accordance with the DMH Psychotropic Medication Guidelines*	32%
3.	*The PPN justifies the need for intraclass polypharmacy*	24%
4.	*The PPN documents the risks of the polypharmacy including drug-to-drug interactions and cumulative side-effects*	6%

Recommendation 3, October 2007:
Provide ongoing feedback and mentoring by senior psychiatrists to improve compliance and correct deficiencies outlined above.

Findings:
Same as in F.1.b, recommendation #3.

Recommendation 4, October 2007:
Identify patterns and trends regarding high-risk medication uses and implement corrective and educational actions.

Findings:
ASH has yet to implement this recommendation. The facility recently

established a Medication Management EP Performance Improvement Committee and plans to utilize this process to address this recommendation. Reportedly, the committee's review and analysis will be forwarded to the P&T Committee and the Medical Executive Committee for their review and feedback

Other findings:
This monitor reviewed the charts of individuals receiving long-term treatment with benzodiazepines (#10) and/or anticholinergic medications (#8) and individuals receiving various forms of polypharmacy (#5). The reviews found some improvement in the documentation of the risks of each medication, particularly in the charts that contain the new format of monthly progress notes. However, the reviews found that some individuals are still receiving long-term regular treatment with benzodiazepines (lorazepam and/or clonazepam) and/or anticholinergic medications (benztropine and/or diphenhydramine) without documented justification. Regarding polypharmacy, there continues to be general evidence of inadequate documentation of the rationale for polypharmacy, associated risks, including drug-drug interactions and/or attempts to simplify/optimize the regimen

The following tables outline examples of the facility's practice. The diagnoses are listed only if they signify conditions that increase the risk of continued use.

Benzodiazepine use:

Individual	Medication(s)	Diagnosis
SMB	Lorazepam (and lorazepam PRN)	Borderline Intellectual Functioning and Learning Disorder NOS

GP	Lorazepam (and lorazepam PRN)	Dementia Due to General Medical Condition without Behavioral Disturbance and Polysubstance Dependence
BWM	Lorazepam	Other (Unknown) Substance Abuse
TLW	Lorazepam	Polysubstance Dependence
AA	Lorazepam	Polysubstance Dependence
ALS	Lorazepam (and lorazepam PRN)	Other (Unknown) Substance Abuse
DWH	Clonazepam (and lorazepam PRN)	Other (Unknown) Substance Abuse
PNC	Clonazepam (and lorazepam PRN)	Other (Unknown) Substance Abuse
KSC	Clonazepam	Polysubstance Dependence
BO	Clonazepam (and benztropine)	Polysubstance Dependence and Dementia NOS

Anticholinergic use:

Individual	**Medication(s)**	**Diagnosis**
MLD	Benztropine	Borderline Intellectual Functioning (MMSE not done as indicated)
MEB	Diphenhydramine	Cognitive Disorder NOS
WJB	Trihexyphenidyl	Borderline Intellectual Functioning
TBR	Benztropine and diphenhydramine	Cognitive Disorder NOS
AS	Benztropine	Mild Mental Retardation
GG	Diphenhydramine	Mild Mental Retardation (MMSE 29/30 cannot find document in chart)

GP	Diphenhydramine	Dementia Due to General Medical Condition (Neurosyphilis) without Behavioral Disturbance (MMSE not done as indicated)		
BO	Benztropine (and clonazepam)	Dementia NOS		

Polypharmacy use:

Individual	Medication(s)	Diagnosis
PD	Ziprasidone, risperidone, lithium, divalproex, haloperidol (back up), sertraline, lorazepam (PRN) and chlorpromazine (PRN)	Polysubstance Dependence
RA	Ziprasidone, aripiprazole, diazepam, citalopram and haloperidol, lorazepam and benztropine (back up), diphenhydramine (PRN),	Other (or Unknown) Substance Abuse
CDB	Fluphenazine, quetiapine, risperidone, trazodone, divalproex, benztropine and fluphenazine (PRN)	Polysubstance Dependence
WDB	Quetiapine, aripiprazole, risperidone and risperidone Consta, benztropine	Polysubstance Dependence
JGC	Risperidone, fluphenazine, buproprion, trihexyphenidyl, risperidone (PRN), haloperidol (PRN), trihexyphenidyl (PRN)	Polysubstance Dependence

		Compliance: Partial. **Current recommendations**: 1. Monitor the use of benzodiazepines, anticholinergics and polypharmacy based on at least a 20% sample. 2. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period). 3. Provide ongoing feedback and mentoring by senior psychiatrists to improve compliance and correct the deficiencies outlined above. 4. Identify patterns and trends regarding use of benzodiazepines, anticholinergics and polypharmacy and implement corrective and educational actions.
F.1.d	Each State hospital shall ensure the monitoring of the metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Standardize the monitoring instruments relevant to this requirement for use across facilities and ensure that the indicators address vital signs monitoring for individuals receiving clozapine. **Findings:** The DMH has yet to implement this recommendation. **Recommendation 2, October 2007:** Monitor this requirement based on a 20% sample of the appropriate total target population. **Findings:** ASH used its current monitoring tool to assess compliance (September 2007 to February 2008). The average sample was 21% of the individuals receiving new generation antipsychotic medications. The

following table outlines the indicators and corresponding mean compliance rates regarding new generation antipsychotic medications as a group:

1.	*Use based on documentation of benefits and tolerability*	38%
2.	*Justification in PPN with diagnosis of dyslipidemia*	15%
3.	*Justification in PPN with diagnosis of diabetes*	18%
4.	*Justification in PPN with diagnosis of obesity*	17%
5.	*Justification in PPN with diagnosis of hyperprolactinemia (for risperidone only)*	2%
6.	*Appropriate baseline and periodic monitoring of family/personal risk factors*	74%
7.	*Appropriate baseline and periodic monitoring of BMI*	48%
8.	*Appropriate baseline and periodic monitoring of waist circumference*	61%
9.	*Appropriate baseline and periodic monitoring of triglycerides*	80%
10.	*Appropriate baseline and periodic monitoring of cholesterol*	80%
11.	*Appropriate baseline and periodic monitoring of fasting blood glucose*	71%
12.	*Appropriate baseline and periodic monitoring of Glycosylated HgBA1C levels*	86%
13.	*Appropriate baseline and periodic monitoring of EKG for individuals receiving ziprasidone*	77%
14.	*Appropriate baseline and periodic monitoring of EKG for other new generation antipsychotics*	69%
15.	*Appropriate baseline and periodic monitoring of blood counts (WBC/ANC) for individuals receiving clozapine*	87%
16.	*PPN documentation of potential and actual risks for*	14%

	each medication used	
17.	*Treatment modified in an appropriate and timely manner to address identified risks*	35%

The above data did not show improvement in compliance since the last review period. The facility anticipates improved compliance with continued feedback to psychiatrists and the utilization of senior psychiatrists in this process.

Recommendation 3, October 2007:
Provide ongoing feedback and mentoring by senior psychiatrists to improve compliance and correct the deficiencies outlined by this monitor above.

Findings:
Same as in Findings for Recommendation 3 in F.1.b.

Other findings:
This monitor reviewed the charts of 10 individuals who are receiving new-generation antipsychotic agents and are suffering from a variety of metabolic disorders. The following table outlines the initials of the individuals, the medication(s) used and the metabolic disorder(s):

Individual	**Medication(s)**	**Diagnosis**
ARC	Risperidone	Obesity
CDB	Quetiapine and risperidone.	Diabetes Mellitus, Obesity and Hyperlipidemia
DJM	Quetiapine and risperidone.	Diabetes Mellitus
EF	Risperidone	Diabetes Mellitus and Obesity
JAB	Olanzapine	Hyperlipidemia and Obesity

JG	Clozapine (and divalproex)	Diabetes Mellitus and Hyperlipidemia
JHC	Olanzapine	Diabetes Mellitus
JJS	Olanzapine (and mirtazapine)	Obesity
JLJ	Clozapine	Hyperlipidemia
TLM	Olanzapine and risperidone	Obesity (undocumented)

This review showed that, in general, the facility provides adequate laboratory monitoring of the metabolic indicators, blood counts and vital signs in individuals at risk. However, deficiencies still exist that must be corrected in order to achieve substantial compliance. The following is an outline of these deficiencies:

1. There was inadequate monitoring of serum lipase and amylase in individuals currently receiving high-risk treatment with olanzapine (JHC), olanzapine and risperidone (TLM) and quetiapine and risperidone (CDB).
2. There was inadequate documentation in the psychiatric progress note of the metabolic status of an individual diagnosed with diabetes mellitus and obesity and currently receiving risperidone, a high-risk medication (EF). The individual had significant abnormalities in HgbA1C and HDL levels and a Body Mass Index (BMI) of 45. The note indicated that the individual had "no side effects" of treatment.
3. The WRP did not include diagnosis, focus, objectives or interventions to address obesity in an individual receiving high-risk medication (risperidone). This individual had documented BMI of 37.8 and had gained 52 pounds during a seven-month period prior to completing the WRP (ARC). The psychiatric progress notes did not address the significant weight gain in this individual.
4. The WRP did not include diagnosis, focus, objectives or

		interventions to address obesity in an individual who had gained 43 pounds since admission to the facility in November 2007 (TLM). The psychiatric progress notes indicated that the individual was free from undue side effects. 5. The WRP did not include diagnosis, focus, objectives or interventions to address obesity in an individual with a BMI of 31 (and waist circumference of more than 50) and currently receiving treatment with olanzapine (JJS). 6. The psychiatric progress notes did not address the metabolic status of an individual who was diagnosed with obesity and received treatment with olanzapine and mirtazapine (JJS). 7. The WRP did not address a BMI of 32 in an individual who received olanzapine and had a diagnosis of Diabetes Mellitus (JHC). 8. The WRP did not include focus, objectives or interventions to address documented diagnoses of hyperlipidemia and obesity in an individual receiving treatment with olanzapine (JAB). 9. The WRP did not include diagnosis, focus, objectives or interventions to address obesity in an individual who had a weight of 307 (his appropriate range was 193-212), was diagnosed with hyperlipidemia and received clozapine (JLJ). 10. There was inadequate monitoring of serum lipids in an individual (DJM) who was diagnosed with Diabetes Mellitus and had significant elevation in triglyceride level (June 2007) at 317. In addition, the WRP and the psychiatric progress notes did not address the status of dyslipidemia and the WRP did not include corresponding diagnosis, focus, objectives or interventions. The individual received treatment with quetiapine and risperidone. 11. The WRP did not include focus, objectives or interventions to address documented diagnosis of hyperlipidemia in an individual who received treatment with quetiapine and risperidone (CDB). **Compliance:** Partial.

		Current recommendations: 1. Standardize the monitoring tool regarding the use of new generation antipsychotic medications. 2. Ensure that the monitoring indicator regarding serum amylase/lipase also include quetiapine. 3. Monitor the use of new generation antipsychotic medications based on at least a 20% sample. 4. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period). 5. Provide ongoing feedback and mentoring by senior psychiatrists to improve compliance and correct the deficiencies outlined above. 6. Identify patterns and trends regarding use of new generation antipsychotic medications and implement corrective and educational actions.
F.1.e	Each State hospital shall ensure regular monitoring, using a validated rating instrument (such as AIMS or DISCUS), of tardive dyskinesia (TD); a baseline assessment shall be performed for each individual at admission with subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication, and every 3 months if the test is positive, TD is present, or the individual has a history of TD.	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Monitor this requirement in all individuals who are diagnosed with abnormal movement disorder or have history of this disorder. **Findings:** ASH used the newly standardized DMH Tardive Dyskinesia Auditing Form to assess most compliance items (January and February 2008). The average sample varied from 14 to 54% depending on the applicable indicator. The following is an outline of the indicators and corresponding mean compliance rates (data regarding indicator #1 was derived from the DMH Admission Psychiatric Assessment Auditing Form and the average sample was 31%):

		5.	*The AIMS is completed*	95%
		2.	*Subsequent monitoring of the individual every 12 months while he/she is receiving antipsychotic medication.*	75%
		3.	*And every 3 months if the test (AIMS or DISCUS) is positive, TD is present, or the individual has a history of TD.*	40%
		4.	*If an older generation antipsychotic is used, there is evidence in PPN or monthly progress note of justification of using the older generation medication.*	22%
		5.	*A neurology consultation/TD Clinic evaluation was completed as indicated.*	33%
		6.	*Monthly progress notes for the past 3 months indicate that antipsychotic treatment has been modified to reduce risk or there documentation of rationale for continuation.*	39%
		7.	*Diagnosis of TD is listed on Axis I and/or III (for current diagnosis).*	50%
		8.	*Tardive Dyskinesia is included in Focus 6 of the WRP.*	30%
		9.	*The WRP reflect objectives and interventions for Tardive Dyskinesia.*	30%

Recommendation 2, October 2007:
Develop and implement a policy and procedure to ensure that:

a. The diagnoses listed on the WRP are aligned with those listed in psychiatric documentation, including TD;
b. TD is recognized as one of the foci of hospitalization and that appropriate objectives and interventions are identified for treatment and/or rehabilitation;
c. The individuals receive appropriate periodic screening; and
d. The individuals receive care at a specialized TD clinic.

		Findings: ASH did not address this recommendation. **Other findings:** This monitor reviewed the charts of eight individuals (AE, DRS, EDS, JMW, LG, ODM, TLG and WCB) who were identified in the facility's current database as having TD. The database identified 23 individuals in total. This review indicated that the facility has made some progress as follows: 1. Admission AIMS tests were completed in all the cases reviewed (the test was not available for review in the chart of one individual, LG who was admitted in 2001). 2. Quarterly AIMS were completed in some cases (AE, EDS and TLG). 3. The WRPs included tardive dyskinesia as a diagnosis with corresponding focus, objectives and interventions in several cases (LG and TLG). 4. Some of the individuals' objectives were appropriately based on learning outcomes (JMW, LG, TLG and WCB). 5. Some of the charts document attempts to use safer antipsychotic medication alternatives in most individuals (DRS). However, this review also showed a pattern of deficiencies as follows: 1. The WRP identified TD as a diagnosis but did not include corresponding focus, objectives or interventions (DRS, EDS and ODM). 2. Some WRPs include unattainable objectives for individuals suffering from TD (AW). 3. AIMS test was not conducted on a quarterly basis as required for several individuals (DRS, JMW, ODM and WCB). For an individual who refused the examination (DRS), there was no documentation of

		follow-up attempts to complete the test. 4. There was evidence of regular treatment with anticholinergic medications without monitoring or documentation of the risks of this treatment (DRS, EDS, JMW and TLG). **Compliance:** Partial. **Current recommendations:** 1. Develop and implement a policy and procedure to ensure that: a. The diagnoses listed on the WRP are aligned with those listed in psychiatric documentation, including TD; b. TD is recognized as one of the foci of hospitalization and that appropriate objectives and interventions are identified for treatment and/or rehabilitation; c. The individuals receive appropriate periodic screening; and d. The individuals receive care at a specialized TD clinic. 2. Monitor the use of new generation antipsychotic medications based on at least a 20% sample. 3. Provide data analysis that evaluates areas of low compliance and delineates areas of relative improvement (during the reporting period and compared to the previous period). 4. Provide ongoing feedback and mentoring by senior psychiatrists to improve compliance and correct the deficiencies outlined above.
F.1.f	Each State hospital shall ensure timely identification, reporting, data analyses, and follow up remedial action regarding all adverse drug reactions ("ADR").	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Provide instruction to all clinicians regarding significance and proper methods of reporting ADRs. **Findings:** ASH developed draft Guidelines for Completing the ADR Reporting and

		Monitoring Form (April 16, 2008). The draft contains adequate instructions. The facility has to yet to finalize the guidelines. **Recommendation 2, October 2007:** Increase reporting of ADRs and provide data regarding ADRs reported during each review period, compared with the previous two periods. **Findings:** ASH did not implement this recommendation. During this review period, 32 ADRs were reported compared to 36 during the previous period. **Recommendation 3, October 2007:** Finalize and implement the draft policy and procedure regarding ADRs. **Findings:** The facility revised its AD regarding ADR Reporting and Monitoring (April 16, 2008). The draft AD has an adequate ADR Reporting tool. **Recommendation 4, October 2007:** Improve current tracking log and data analysis systems to provide adequate basis for identification of patterns and trends of ADRs. **Findings:** ASH has yet to implement this recommendation. **Recommendation 5, October 2007:** Provide information for each review period regarding each ADR that required additional medication to treat and/or resulted in increased length of hospitalization, transfer to acute care setting, serious morbidity or death, including any intensive case analysis done and any follow-up corrective/educational actions.

		Findings: ASH reported that during this review period, one ADR required additional medication(s) to treat, one resulted in increased length of hospitalization/transfer to acute care setting and none resulted in serious morbidity or death. However, review of the facility's intensive case analyses (ICAs) performed during this review period (#6) indicates that at least several individuals did experience ADRs that resulted in increased length of hospitalization/transfer to acute care setting. The ICAs themselves were adequate. **Compliance:** Partial. **Current recommendations**: 1. Finalize and implement the draft instructions and AD regarding ADR reporting. 2. Increase reporting of ADRs and provide data regarding ADRs reported during each review period, compared with the previous period. 3. Improve current tracking log and data analysis systems to provide adequate basis for identification of patterns and trends of ADRs. 4. Provide information for each review period regarding each ADR that required additional medication to treat and/or resulted in increased length of hospitalization, transfer to acute care setting, serious morbidity or death, including any intensive case analysis done and any follow-up corrective/educational actions. 5. Ensure accuracy of the data submitted to the CM.
F.1.g	Each State hospital shall ensure drug utilization evaluation ("DUE") occurs in accord with established, up-to-date medication guidelines that shall specify indications, contraindications, and screening and monitoring requirements for all	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Develop and implement a DUE policy and procedure, based on the individualized medication guidelines, to ensure systematic review of all

	psychotropic medications; the guidelines shall be in accord with current professional literature. A verifiably competent psychopharmacology consultant shall approve the guidelines and ensure adherence to the guidelines.	medications, with priority given to high-risk, high-volume uses. **Findings:** ASH developed a draft AD regarding DUE Reporting and Monitoring. This draft does not address the recommendation regarding systematic review of all medications, with priority given to high-risk, high-volume uses. **Recommendations 2-4, October 2007:** • Conduct DUEs that include review of the use, analysis of trends/patterns, conclusions regarding findings and recommendations for corrective actions/education activities based on the review. • Ensure proper aggregation and analysis of DUE data to determine practitioner and group patterns and trends. • Ensure that the individualized medication guidelines are continually updated to reflect current literature, relevant clinical experience and current professional practice guidelines. **Findings:** ASH has yet to implement these recommendations. **Compliance:** Partial. **Current recommendations:** 1. Develop and implement a DUE policy and procedure, based on the individualized medication guidelines, to ensure systematic review of all medications, with priority given to high-risk, high-volume uses. 2. Conduct DUEs that include review of the use, analysis of trends/patterns, conclusions regarding findings and recommendations for corrective actions/education activities based on the review.

		3. Ensure proper aggregation and analysis of DUE data to determine practitioner and group patterns and trends. 4. Ensure that the individualized medication guidelines are continually updated to reflect current literature, relevant clinical experience and current professional practice guidelines.
F.1.h	Each State hospital shall ensure documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances ("MVR") consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Implement the new policy and procedure regarding medication variances and ensure that this policy applies to all involved disciplines (medicine, psychiatry, nursing and pharmacy). **Findings:** ASH has yet to implement this recommendation. The facility finalized its Nursing Procedure, Medication Variances (#310.1) on February 25, 2008. The procedure contains an adequate data collection tool. The facility developed draft AD, Medication Variances that aligns with the procedure. The procedure was approved for pilot use on Program IV. The facility has yet to implement this procedure on all units and to finalize its AD. **Recommendation 2, October 2007:** Provide written instructions to all clinicians regarding the significance and proper methods of MVR. **Findings:** ASH's Nursing Procedure #310.1 contains adequate instructions. **Recommendation 3, October 2007:** Develop and implement adequate tracking log and data analysis systems and identify patterns and trends related to medication variances facility-wide.

		Findings: ASH has yet to implement this recommendation. **Recommendation 4, October 2007:** Develop and implement an intensive case analysis procedure based on established severity/outcome thresholds. The analysis must include proper discussion of history/circumstances, preventability, contributing factors and recommendations. **Findings:** ASH has implemented this recommendation. **Other findings:** ASH presented data regarding medication variances during this review period (September 2007 to February 2008)). However, the data do not permit conclusions regarding the status of compliance because they were limited to Program IV (only five out of 34 treatment units in the facility). According to these data, no variance resulted in harm to an individual during the reporting period. **Compliance:** Partial. **Current recommendations**: 1. Finalize and implement the AD regarding Medication Variances. 2. Implement the new policy and procedure regarding medication variances facility-wide. 3. Develop and implement adequate tracking log and data analysis systems and identify patterns and trends related to medication variances facility-wide. 4. Present data regarding medication variances, including number of actual and potential variances, number of variances in each

		category, outcomes of the variances and any intensive case analysis performed during the reporting period.
F.1.i	Each State hospital shall ensure tracking of individual and group practitioner trends, including data derived from monitoring of the use of PRNs, Stat medications, benzodiazepines, anticholinergics, and polypharmacy, and of ADRs, DUE, and MVR consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Same as in F.1.a through F.1.h. **Findings:** Same as in F.1.a through F.1.h. **Recommendation 2, October 2007:** Improve IT resources to the pharmacy to facilitate the development of databases regarding medication use. **Findings:** ASH did not address this recommendation. **Compliance:** Partial. **Current recommendations**: 1. Same as in F.1.a through F.1.h. 2. Improve IT resources to the pharmacy to facilitate the development of databases regarding medication use.
F.1.j	Each State hospital shall ensure feedback to the practitioner and educational/corrective actions in response to identified trends consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Same as in F.1.b and F.1.i. **Findings:** Same as in F.1.b and F.1.i.

		Compliance: Partial. **Current recommendations**: Same as in F.1.b and F.1.i.
F.1.k	Each State hospital shall ensure integration of information derived from ADRs, DUE, MVR, and the Pharmacy & Therapeutics, Therapeutics Review, and Mortality and Morbidity Committees consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Same as above. **Findings:** Same as above. **Other findings:** As mentioned earlier, ASH has established a Medication Management EP Performance Improvement Team. The facility plans to utilize this new process to ensure compliance with this requirement. **Compliance:** Partial. **Current recommendations**: Same as in F.1.b and F.1.i.
F.1.l	Each State hospital shall ensure that all physicians and clinicians are verifiably competent, consistent with generally accepted professional standards of care, in appropriate medication management, interdisciplinary team functioning, and the integration of behavioral and pharmacological treatments.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h. **Findings:** Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h.

		Compliance: Partial. **Current recommendations**: Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h.
F.1.m	Each State hospital shall review and ensure the appropriateness and safety of the medication treatment, consistent with generally accepted professional standards of care, for:	**Compliance:** Partial.
F.1.m.i	all individuals prescribed continuous anticholinergic treatment for more than two months;	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Same as in F.1.c. **Findings:** Same as in F.1.c. **Recommendation 2, October 2007:** Ensure that this practice is triggered for review by the appropriate clinical oversight mechanism, with corrective follow-up actions by the psychiatry department. **Findings:** Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h. **Current recommendations**: 1. Same as in F.1.c. 2. Same as in D.1.b, D.1.c, D.1.f.viii and F.1.a through F.1.h.
F.1.m.ii	all elderly individuals and individuals with cognitive disorders who are prescribed	**Current findings on previous recommendation:**

	continuous anticholinergic treatment regardless of duration of treatment;	**Recommendation, October 2007:** Same as above. **Findings:** Same as above. **Current recommendations**: Same as above.
F.1.m.iii	all individuals prescribed benzodiazepines as a scheduled modality for more than two months;	**Current findings on previous recommendation:** **Recommendation, October 2007:** Same as above. **Findings:** Same as above. **Current recommendations**: Same as above.
F.1.m.iv	all individuals prescribed benzodiazepines with diagnoses of substance abuse or cognitive impairments, regardless of duration of treatment; and	**Current findings on previous recommendation:** **Recommendation, October 2007:** Same as above. **Findings:** Same as above. **Current recommendations**: Same as above.
F.1.m.v	all individuals with a diagnosis or evidencing symptoms of tardive dyskinesia.	**Current findings on previous recommendation:**

		Recommendation, October 2007: Same as F.1.e. **Findings:** Same as F.1.e. **Current recommendations**: Same as F.1.e.
F.1.m.vi	all individuals diagnosed with dyslipidemia, and/or obesity, and/or diabetes mellitus who are prescribed new generation antipsychotic medications	**Current findings on previous recommendation:** **Recommendation, October 2007:** Same as in F.1.d. and F.1.g. **Findings:** Same as in F.1.d. and F.1.g. **Current recommendations**: Same as in F.1.d. and F.1.g.
F.1.n	Each State hospital shall ensure that the medication management of individuals with substance abuse disorders is provided consistent with generally accepted professional standards of care.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Same as in C.2.o and F.1.c. **Findings:** Same as in C.2.o and F.1.c. **Compliance:** Partial. **Current recommendations**: Same as in C.2.o and F.1.c.

F.1.o	Metropolitan State Hospital shall provide a minimum of 16 hours per year of instruction, through conferences, seminars, lectures and /or videotapes concerning psychopharmacology. Such instruction may be provided either onsite or through attendance at conferences elsewhere.	

2. Psychological Services		
	Each State hospital shall provide adequate and appropriate psychological supports and services that are derived from evidence-based practice or practice-based evidence and are consistent with generally accepted professional standards of care, to individuals who require such services; and:	**Methodology:** Interviewed: 1. Individuals JC and TF 2. Aener Gagnom, RN 3. Alice Dodge, LCSW, Social Work 4. Brooke Heather, RT 5. Cameron Grant, ASH Police Officer 6. Chris McDonald, PsyD, Admissions Psychologist 7. Cindy Duke, PhD, Neuropsychologist 8. Christine Mathiesen, PsyD, Director C-PAS 9. Dante Karas, Assistant Mall Director 10. Diane Imrem, PsyD, Chief of Psychology 11. Diane Walker, PhD, Psychologist, PBS #2 Team Leader 12. Don Johnson, PhD, Psychologist 13. Donna Nelson, Standards Compliance Director 14. Glenn Potts, PhD, Psychologist, PBS #3 Team Leader 15. Henry Ahlstrom, PhD, Psychologist 16. Jaret McMillan, RN 17. Jeffrey Teuber, PhD, Senior Psychologist, PBS Team Leader 18. Joe DeBruin, PhD, Psychologist, Chair-Department of Psychology 19. John De Morales, Executive Director 20. Karen Dubiel, Assistant to Clinical Administrator 21. Leslie Bolin, PhD, Neuropsychologist 22. Luis Santiago, BY CHOICE Coordinator 23. Marie Diets-Strover, Special Education Teacher 24. Matt Hennessy, PhD, Psychologist, Mall Director 25. Michael Tandy, PhD, Psychologist 26. Patrick O'Rourke, Unit Supervisor. 27. Rich Morey, PhD, Senior Psychologist 28. Theresa George, PhD, PBS Supervisor 29. William Tandy, PhD, Psychologist

		Reviewed: 1. Charts of the following 32 individuals: ADJ, AE, AF, AJ, BRD, CLJ, DB, DJB, DWR, EO, FJE, IC, IW, JGM, JIL, JR, JT, JW, KK, LC, LWA, MG, MPR, MSB, RC, REZ, SCK, SRB, TLC, TLW, WT and WTM 2. ASH Behavioral Consultation Committee Attendance Record 3. ASH Key Indicator/Trigger Reporting Manual 4. ASH NEUROPSYCHOLOGICAL Services Overview 5. ASH Trigger Report and Trend Graphs 6. Behavioral Consultation Committee Meeting Minutes 7. Behavioral Guidelines 8. BY CHOICE Individual Satisfaction Survey 9. BY CHOICE Monthly Fidelity Check 10. BY CHOICE WRP Audit Tool form and Instructions 11. BY CHOICE WRP Audit Tool Form and Instructions 12. CA DMH Key Indicators: Triggers and Physical Health Indicators 13. DCAT Behavior Guideline Fidelity Checks 14. DCAT Fidelity Checks 15. Enhanced Trigger Review meeting minutes 16. List of individuals in need of PBS plans 17. List of individuals needing neuropsychological services 18. List of individuals receiving DCAT services 19. List of individuals that need neuropsychological services 20. List of individuals with behavioral guidelines 21. Neuropsychology Service Data 22. PBS "Special Connection" Training Outcome 23. PBS Competency Training Record 24. PBS Team Behavior Guideline Fidelity Checks 25. PBS Training Documentation 26. PBS Training Sign-In Sheet 27. PSR Mall Services Hours by Disciplines 28. Psychology Assessment Audit form 29. System-Wide PBS Programming Plan

		Observed: 1. WRPC for CM, Program III, Unit 21 2. WRPC for MG, Program IV, Unit 9A 3. Mall group: Depression and Crisis Management 4. Mall group: Symptom Management 5. Mall group: Coping with Anxiety 6. Mall group: "Ready-Set-Go" 7. Mall group: Substance Abuse Recovery 8. Mall group: Social Skills Through Music
F.2.a	Each State hospital shall ensure that it has positive behavior support teams (with 1 team for each 300 individuals, consisting of 1 clinical psychologist, 1 registered nurse, 2 psychiatric technicians (1 of whom may be a behavior specialist), and 1 data analyst (who may be a behavior specialist) that have a demonstrated competence, consistent with generally accepted professional standards of care, in the following areas:	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Recruit additional staff to fulfill the required number of teams to meet the 1:300 ratio as stated in the EP. **Findings:** This monitor's documentation review and interview of the Chief of Psychology found that ASH does not have the required number of PBS teams to meet the 1:300 ratio as stated in the EP. ASH has three out of the four PBS teams needed to fulfill this requirement. **Recommendation 2, October 2007:** Ensure that all direct care staff system-wide are competent in the principles and practice of PBS. **Findings:** This monitor's documentation review and interview of Theresa George (Senior Supervising Psychologist and PBS Team Leader) found that training had been conducted on an ongoing basis. All new employees received training during the New Employee Orientation. Additional unit staff training was conducted on September 10 and December 17, 2007;

		and January 23 and February 27, 2008. Training for the Psychiatry Department was conducted on February 7, 2008. All staff in Programs IV and V have been offered the eight hours of training. ASH is using the University of Kansas "Special Connections" project for staff training on PBS. **Compliance:** Partial. **Current recommendations**: 1. Recruit additional staff to fulfill the required number of teams to meet the 1:300 ratio as stated in the EP. 2. Ensure that all direct care staff system-wide are competent in the principles and practice of PBS.
F.2.a.i	the development and use of positive behavior support plans, including methods of monitoring program interventions and the effectiveness of the interventions, providing staff training regarding program implementation, and, as appropriate, revising or terminating the program; and	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Ensure that all PBS staff members receive systematic training in all aspects of the PBS plans, including the relationship between PBS and recovery principles. **Findings:** This monitor's documentation review found that ASH had all its PBS and DCAT staff members take the University of Kansas "Special Connections" program and post-tests on PBS. A review of the post-test scores found that those who took the training passed the post-test, obtaining a minimum of 90% correct. However, ASH did not have any PBS plans developed and implemented over the last six months (September 2007 to February 2008). **Recommendations 2-4, October 2007:** • Conduct treatment implementation fidelity checks regularly.

		• Revision of treatment plans should be directly related to the outcome data and reported at all scheduled WRPCs of the individual. • Data should be reviewed regularly to determine treatment effectiveness and to decide if plans should be revised, terminated, or if further training of level of care staff is necessary to improve treatment implementation. **Findings:** This monitor's documentation review found that PBS and DCAT teams had conducted fidelity checks on 82% of the behavior guidelines developed with PBS/DCAT support (documentation indicated that the PBS/DCAT staff collaborated in the development of 44 behavior guidelines). Furthermore, there are nine WRPTs without a psychologist. The PBS/DCAT team members participate in these WRPTs to assist with data reporting and documentation. This monitor's review of six behavior guidelines (AJ, IW, JR, JT, JW and WT) found that the staff (PBS/DCAT and WRPTs) need to identify better criteria to determine when a behavior guideline is ineffective (despite modifications/revisions) and is referred to the PBS/BCC teams for a more focused assessment and intervention (PBS/BCC) plan. This monitor's review of the behavior guidelines found many deficits. For example, in one case reviewed, it took a period of nearly two month from the date of referral to plan implementation (WT). Functional aspects of behaviors are not written clearly, for example "to draw attention to his concern" and to relieve frustration" (WT). Plans are incomplete or entries made in the wrong sections (JR). Prevention Strategies are incorrect; for example the prevention strategy for JT reads, "Mr. T. stated I don't like . . . He may use this phrase to communicate an internal state of worry, anxiety, or fear." Decisions to intervene or change interventions are questionable. For example, AH's

		behaviors were decelerating when a PBS plan was developed. Data analysis and interpretation/conclusion needs improvement; IW's behavior was on an upward trend before the change in lunch schedule, so the assumption that the lunch schedule was the reason for the behavior escalation is untenable. None of the behavior guidelines maximized treatment efficacy by incorporating appropriate recreational activities, exercise, or Mall group participation in the intervention plan. There were a number of graphs derived from behavior guidelines (AT#'s: 054979-0, 055085-5, 055342-0, 054892, 057350-1, and 057477-2) that showed good outcomes from the behavioral guidelines. The protocols were not available for review. **Recommendation 5, October 2007:** Develop a training protocol for all PBS plans to ensure that all staff who will be responsible for implementing the plan are consistently and appropriately trained prior to implementation of the plan (i.e., behavioral rehearsals, demonstrations, role plays, modeling). **Findings:** This monitor's documentation review and interview with PBS/DCAT staff indicated that PBS/DCAT members train all staff involved in implementing the intervention plans. Training includes having the staff read, explain, and demonstrate the components/steps in the protocol. PBS/DCAT does not have sufficient staff to support all units on the development and implementation of all behavior guidelines. According to Theresa George, all behavior guidelines are sent to her for review to ensure that the behavior guidelines use positive intervention procedures. **Compliance:** Partial.

		Current recommendations: 1. Ensure that all PBS staff members receive systematic training in all aspects of the PBS plans, including the relationship between PBS and recovery principles. 2. Conduct treatment implementation fidelity checks regularly. 3. Revision of treatment plans should be directly related to the outcome data and reported at all scheduled WRPCs of the individual. 4. Data should be reviewed regularly to determine treatment effectiveness and to decide if plans should be revised, terminated, or if further training of level of care staff is necessary to improve treatment implementation. 5. Develop a training protocol for all PBS plans to ensure that all staff who will be responsible for implementing the plan are consistently and appropriately trained prior to implementation of the plan (i.e., behavioral rehearsals, demonstrations, role plays, modeling).
F.2.a.ii	the development and implementation of a facility-wide behavioral incentive system, referred to as "By CHOICE" that encompasses self-determination and choice by the individuals served.	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Ensure all staff correctly implements the BY CHOICE program. **Findings:** This monitor's document review found that ASH has conducted fidelity checks on staff knowledge and implementation of the BY CHOICE program, and knowledge of the BY CHOICE program by individuals. ASH used the BY CHOICE Monitoring Form: Competency and Fidelity Check (Individual) to evaluate the individuals' knowledge of and participation in the program, reporting 69% compliance. The table below showing the census each month (N), the number of individuals audited (n), and the percentage of compliance obtained (%C) is a

summary of the facility's data.

	Oct	Nov	Dec	Jan	Feb	Mean
N	993	1014	1028	1051	1044	
n	18	69	49	191	138	
%S	2	7	5	18	13	
%C	67	62	67	69	77	69

ASH used the BY CHOICE Monitoring Form: Competency and Fidelity Check (Staff) to evaluate staff knowledge and implementation of the program, reporting 60% compliance. The table below showing the number of Level of Care staff for each month (N), the number of staff audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

	Oct	Nov	Dec	Jan	Feb	Mean
N	1210	1210	1210	1199	1210	
n	9	27	0	52	61	
%S	1	2	0	4	5	
%C	69	74	0	73	80	60

Recommendation 2, October 2007:
Implement the program as per the manual.

Findings:
This monitor's interview of the BY CHOICE Coordinator, documentation review, and visits to the BY CHOICE stores found that ASH has implemented the BY CHOICE program as per the manual. However, there are aspects of the program that need further improvement (e.g. engaging the individual in point allocation, proper documentation in the Present Status section of the individual's WRP) to fully meet EP requirements. According the BY CHOICE Coordinator, the BY CHOICE incentive program is offered to all individuals in ASH except for those

under the 6600 commitment code (SVP). These individuals are expected to be transferred to Coalinga State Hospital as early as May 2008.

Recommendation 3, October 2007:
BY CHOICE point allocation should be determined by the individual at the WRPC, with facilitation by the staff.

Findings:
ASH audited Program IV for the month of September and hospital-wide for the remaining months using item #1 from he BY CHOICE Monitoring Form (*Individual has input into the reallocation of points as evidenced by documentation in the WRP*) to evaluate this recommendation, reporting 30% compliance. The table below showing the census per month (N), the number of charts audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
N	975	993	1014	1028	1051	1044	
n	100	149	205	285	234	249	
%S	10	15	20	28	22	24	
%C #1	21	17	22	34	39	45	30

This monitor reviewed six charts (ADJ, AF, EO, FJE, MG and SCK). Two of the WRPs in the charts (MG and SCK) had documentation in the Present Status section indicating that the individual was a participant in the point allocation process, and the remaining four did not (ADJ, AF, EO and FJE). This monitor also reviewed 17 BY CHOICE Individual Satisfaction Survey results. Only one individual responded with "Always" to indicate his participation in point allocation during the team conference, the remaining 16 responded with a "Never."

Recommendation 4, October 2007:
Report BY CHOICE point allocation in the Present Status section of the individual's case formation and update at every scheduled WRPC.

Findings:
ASH audited Program IV for the month of September and hospital-wide for the remaining months using item #2 from the BY CHOICE Monitoring Form (*Progress of By Choice status from month to month is discussed as evidenced by documentation in the Present Status Section of the WRP*) to evaluate this recommendation, reporting 15% compliance. The table below showing the census per month (N), the number of charts audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
N	975	993	1014	1028	1051	1044	
n	100	149	205	285	234	249	
%S	10	15	20	28	22	24	
%C #2	19	11	15	14	16	12	15

Findings:
This monitor reviewed ten charts (ADJ, DJB, EO, FJE, JGM, JIL, MPR, REZ, SRB and WTM). Three of the WRPs in the charts (DJB, EO and MPR) had documentation of the individual's progress in the BY CHOICE incentive system. The remaining seven (ADJ, FJE, JGM, JIL, REZ, SRB and WTM) did not.

Compliance:
Partial.

Current recommendations:
1. Ensure all staff correctly implements the BY CHOICE program.
2. Implement the program as per the manual.

		3. BY CHOICE point allocation should be determined by the individual at the WRPC, with facilitation by the staff. 4. Report BY CHOICE point allocation in the Present Status section of the individual's case formation and update at every scheduled WRPC.
F.2.b	Each State Hospital shall ensure that the Chief of Psychology has the clinical and administrative responsibility for the Positive Behavior Supports Team and the By CHOICE incentive program.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Continue current practice. **Findings:** The Chief of Psychology at ASH continues to have the clinical and administrative responsibility for the Positive Behavior Supports Team and the BY CHOICE incentive program **Compliance:** Full. **Current recommendation**: Continue current practice.
F.2.c	Each State Hospital shall ensure that:	**Compliance:** Partial.
F.2.c.i	behavioral assessments include structural and functional assessments and, as necessary, functional analysis;	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Train all PBS team members in functional assessment, data collection, data analysis, graphing, plan implementation and data interpretation. **Findings:** This monitor's documentation review found that ASH had all its PBS

		and DCAT staff members take the University of Kansas "Special Connections" program and post-tests on PBS. This monitor's review of PBS/DCAT assisted behavior guidelines revealed numerous deficits, as outlined in F2.a.i. **Recommendation 2, October 2007:** Develop a system for identifying and tracking individuals in the hospital who are in need of behavioral interventions. **Findings:** According to the Chief of Psychology, the department has set up a PBS referral tracking log. Individuals needing behavioral interventions are identified through the Task Tracking Form, the unit psychologists, and the trigger system. This monitor's documentation review found that a total of 40 referrals were made to the PBS teams in the last six months. However, per the Chief of Psychology, the referrals were addressed through the development and implementation of behavioral guidelines with support from the PBS/DCAT teams. **Recommendation 3, October 2007:** Use the PBS-BCC pathway for all consultations. **Findings:** ASH continues to the same policy as in previous reports. All consultations are forwarded through the PBS-BCC checklist. This monitor's findings from review of the PBS-BCC checklist are in agreement with the facility's report. **Current recommendations**: 1. Train all PBS team members in functional assessment, data collection, data analysis, graphing, plan implementation and data interpretation.

		2. Develop a system for identifying and tracking individuals in the hospital who are in need of behavioral interventions. 3. Use the PBS-BCC pathway for all consultations.
F.2.c.ii	hypotheses of the maladaptive behavior are based on structural and functional assessments;	**Current findings on previous recommendation:** **Recommendation, October 2007:** Ensure that hypotheses of the maladaptive behaviors are based on structural and functional assessments and clearly stated in the PBS documentation. **Findings:** ASH did not develop and implement any PBS plans in the last six months. Instead, the PBS teams had collaborated with unit staff to develop and implement behavior guidelines as the initial step in addressing individuals' maladaptive behaviors. Structural and functional assessments are not conducted in developing and implementing behavioral guidelines. The process of the PBS teams working with unit staff to develop behavioral guidelines as the initial process to address an individual's maladaptive behaviors is appropriate. However, there needs to be better and timely decision-making to ensure that the individual is referred for a PBS plan, using the PBS-BCC pathway, when behavioral guidelines do not have a significant impact on the individual's maladaptive behaviors. This step is more urgent in individuals who display maladaptive behaviors across settings, as behavioral guidelines are not fully implemented (i.e. staff training across settings, conducting fidelity checks across settings) across settings. **Current recommendation**: Ensure that hypotheses of the maladaptive behaviors are based on structural and functional assessments and clearly stated in the PBS documentation.

F.2.c.iii	There is documentation of previous behavioral interventions and their effects;	**Current findings on previous recommendation:** **Recommendations 1 and 2, October 2007:** • Document previous behavioral interventions. • Document effectiveness of previous interventions. **Findings:** ASH did not develop or implement any PBS plans in the last six months. This monitor reviewed five behavior guidelines (AJ, IW, JR, JT and WT), and none of them contained documentation of previous behavioral interventions. **Current recommendations**: 1. Document previous behavioral interventions. 2. Document effectiveness of previous interventions.
F.2.c.iv	behavioral interventions, which shall include positive behavior support plans, are based on a positive behavior supports model and do not include the use of aversive or punishment contingencies;	**Current findings on previous recommendation:** **Recommendation, October 2007:** Ensure that all behavioral interventions are based on a positive behavioral supports model without any use of aversive or punishment contingencies. **Findings:** ASH reviewed all the behavioral interventions developed and implemented in the last six months, reporting that all of the behavioral guidelines (100% compliance) were based on a positive behavior support model, and that none of them had any use of aversive/punishment contingencies. This monitor reviewed five behavior guidelines (AJ, IW, JR, JT and WT) all the five behavioral guidelines were based on a positive support model.

		Current recommendations: Ensure that all behavioral interventions are based on a positive behavioral supports model without any use of aversive or punishment contingencies
F.2.c.v	behavioral interventions are consistently implemented across all settings, including school settings;	**Current findings on previous recommendations:** **Recommendations 1 and 2, October 2007:** • Ensure that staff across settings is aware of each individual's behavioral plan, and that they receive written plans and training. • Ensure that all behavioral interventions are consistently implemented across all settings, including mall, vocational and education settings. **Findings:** This monitor reviewed five behavioral guidelines (AJ, IW, JR, JT and WT). These behavior guidelines were implemented only on the unit. This monitor's documentation review found that staff responsible for implementing the five behavioral guidelines on the unit had been trained. **Current recommendations**: 1. Ensure that staff across settings is aware of each individual's behavioral plan, and that they receive written plans and training. 2. Ensure that all behavioral interventions are consistently implemented across all settings, including mall, vocational and education settings.
F.2.c.vi	triggers for instituting individualized behavioral interventions are specified and utilized, and that these triggers include excessive use of seclusion, restraint, or	**Current findings on previous recommendation:** **Recommendation 1, October 2007:** Continue to refine the trigger system.

	psychiatric PRN and Stat medication for behavior control;	**Findings:** According to the Chief of Psychology, the Key Indicator/Trigger reporting administrative directive was approved (January 15, 2008) and the Enhanced Trigger Review Committee began regular meetings as of February 27, 2008. A review of ASH's trigger data, the number of PBS plans, and cases reviewed by the BCC indicate that the Psychology staff participating in the trigger review meetings should bring to the attention of the PBS teams and/or the BCC all individuals who display severe maladaptive behaviors. **Recommendation 2, October 2007:** Ensure that staff is aware of the PBS-BCC pathway. **Findings:** According to the Chief of Psychology the PBS-BCC Manual is available on every unit and the ASH Intranet. In addition, documentation showed that this aspect is included as part of the monthly PBS training offered during the New Employee Training. This monitor's interview of members of the WRPTs found that they were familiar with the process of referring individuals to the PBS teams when they exhibit significant maladaptive behaviors. **Current recommendations**: 1. Continue to refine the trigger system. 2. Ensure that staff is aware of the PBS-BCC pathway.
F.2.c.vii	positive behavior support teams and team psychologists integrate their therapies with other treatment modalities, including drug therapy;	**Current findings on previous recommendation:** **Recommendations 1 and 2, October 2007:** • Conduct appropriate structural and functional assessments to derive data-based hypotheses that will guide specific treatment

		options. • Integrate all behavioral interventions with other treatment modalities including drug therapy. **Findings:** ASH did not develop and implement any PBS plans in the last six months and therefore no structural and/or functional assessments were conducted, as such there was no occasion for interdisciplinary collaboration. **Current recommendations**: 1. Conduct appropriate structural and functional assessments to derive data-based hypotheses that will guide specific treatment options. 2. Integrate all behavioral interventions with other treatment modalities including drug therapy.
F.2.c.viii	all positive behavior support plans are specified in the objectives and interventions sections of the individual's Wellness and Recovery Plan;	**Current findings on previous recommendation:** **Recommendations 1 and 2, October 2007:** • Specify PBS plans in the objectives and interventions sections of the individual's WRP plan as outlined in the DMH WRP Manual. • Ensure that WRPTs are aware of the DMH WRP Manual, as the Manual specifies how this is done. **Findings:** This monitor's interview with WRPT members found that they were aware of the DMH WRP Manual. However, ASH did not develop or implement any PBS plans in the last six months, and therefore there were no entries on PBS plans in the Present Status sections of individuals' WRPs.

		Current recommendations: 1. Specify PBS plans in the objectives and interventions sections of the individual's WRP plan as outlined in the DMH WRP Manual. 2. Ensure that WRPTs are aware of the DMH WRP Manual, as the Manual specifies how this is done.
F.2.c.ix	all positive behavior support plans are updated as indicated by outcome data and reported at least quarterly in the Present Status section of the case formulation in the individual's Wellness and Recovery Plan	**Current findings on previous recommendation:** **Recommendations 1 and 2, October 2007:** • Update all PBS plans as indicated by outcome data and document it at every scheduled WRPC in the Present Status section of the individual's case formulation. • Implement the steps that will improve collaboration among all parties that participate in/support PBS plans. **Findings:** ASH did not develop or implement any PBS plans in the last six months, therefore data were not available for this monitor's review. **Current recommendations**: 1. Update all PBS plans as indicated by outcome data and document it at every scheduled WRPC in the Present Status section of the individual's case formulation. 2. Implement the steps that will improve collaboration among all parties that participate in/support PBS plans.
F.2.c.x	all staff has received competency-based training on implementing the specific behavioral interventions for which they are responsible, and performance improvement measures are in place for monitoring the implementation of such interventions.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Ensure that staff is competent in implementing specific behavioral interventions for which they are responsible, and have performance improvement measures in place for monitoring the implementation of such interventions.

		Findings: ASH did not develop or implement any PBS plans in the last six months for this monitor to review for staff training and plan implementation. This monitor's reviewed five behavioral guidelines (AJ, IW, JR, JT and WT). In all cases, staff training had been conducted. However, there is no indication that the staff was trained to competency or of performance improvement measures to monitor accurate implementation of the intervention plans. **Current recommendations:** Ensure that staff is competent in implementing specific behavioral interventions for which they are responsible, and have performance improvement measures in place for monitoring the implementation of such interventions.
F.2.c.xi	all positive behavior support team members shall have as their primary responsibility the provision of behavioral interventions;	**Current findings on previous recommendation:** **Recommendation 1, October 2007:** Ensure that all PBS team members provide PBS services full-time until the needs of all individuals requiring behavioral interventions are met. **Findings:** ASH has three full PBS teams. This monitor's interview with the Chief of Psychology, and PBS team members found that the PBS team members have PBS duties as their full-time jobs. **Recommendation 2, October 2007:** Hire additional staff to add PBS teams to meet the 1:300 ratio. **Findings:** ASH does not have the required number of PBS teams to fulfill this

		requirement. ASH is actively recruiting to fill in the vacant positions. **Recommendation 3, October 2007:** Hire PBS support staff for tasks including data management and graphing. **Findings:** This monitor's interview of the Chief of Psychology and documentation review found that there is a data analyst for each for all three PBS teams. The data analyst's job includes data management and graphing. **Current recommendations:** Hire additional staff to add PBS teams to meet the 1:300 ratio.
F.2.c.xii	the By CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Implement BY CHOICE system-wide. **Findings:** This monitor's documentation review, interview of the BY CHOICE Coordinator, and observation of Mall groups found that ASH has implemented the BY CHOICE incentive system across the facility. The BY CHOICE coordinator has also developed a system whereby redeemable items are brought to the individuals who are unable to get to the incentive stores (e.g. bed-bound individuals). **Recommendation 2, October 2007:** Ensure that BY CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan. **Findings:** ASH audited Program IV for the month of September and facility-wide

for the remaining five months, using items #3 to #6 from the BY CHOICE monitoring form (see below) to address this recommendation, reporting 35%, 20%, 19%, and 9% compliance respectively. The table below showing the census per month (N), the number of charts audited (n), and the percentage of compliance obtained (%C) is a summary of the facility's data.

#3: Whether the individual is on a baseline card or reallocated card is documented in the WRP.

#4: The WRPT reallocated BY CHOICE points during the WRPC as evidenced by documentation in the WRP.

#5: A rationale for BY CHOICE point reallocation is documented in the WRP.

#6: The By Choice point allocation is updated monthly in the individual's WRP.

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
N	975	993	1014	1028	1051	1044	
n	100	149	205	285	234	249	
%S	10	15	20	28	22	24	
%C #3	25	18	31	23	38	76	35
%C #4	16	13	24	28	22	16	20
%C #5	11	9	13	23	26	33	19
%C #6	5	7	0	14	16	12	9

This monitor reviewed ten charts (BRD, CLJ, DB, DWR, IC, KK, LWA, RC, REZ and TLW). Four of WRPs in the charts (DB, IC, KK and RC) contained proper documentation of the individual's BY CHOICE point system. The remaining six (BRD, CLJ, DWR, LWA, REZ and TLW) did not.

		According to the BY CHOICE Coordinator, the poor rate of compliance with this requirement is due to shortage of psychologists in units. Psychologists in the WRPTs are responsible for presenting an individual's BY CHOICE point levels and progress to the team. **Current recommendations**: Ensure that BY CHOICE point allocation is updated monthly in the individual's Wellness and Recovery Plan.
F.2.d	Each State hospital shall ensure that it has at least one developmental and cognitive abilities team (DCAT; consisting of 1 clinical psychologist, 1 registered nurse, 1 social worker, 1 psychiatric technician, and 1 data analyst (who may be a behavior specialist) who have a demonstrated competence, consistent with generally accepted professional standards of care, in assessing individuals with cognitive disorders/challenges; developing therapeutic interventions (including positive behavior supports); advising therapy and rehabilitation providers on the implementation of interventions at the cognitive level of the individuals; and managing discharge processes for individuals with developmental disabilities and cognitive disorders/challenges,. This team shall assume some of the functions of the positive behavior support teams if the individuals they serve also need positive behavioral sup ports.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Ensure that all DCAT team members receive appropriate training. **Findings:** This monitor's documentation review and interview of the Chief of Psychology and PBS/DCAT members found that DCAT team members receive the same training as do the PBS teams. Furthermore, DCAT members have participated in the Neuropsychology Seminar, and completed the on-line training offered by the University of Kansas, except for the Social Work team member who only recently joined the DCAT. **Compliance:** Substantial. **Current recommendations**: Ensure that all DCAT team members receive appropriate training.
F.2.e	Each State Hospital shall develop and implement a Behavioral Consultation Committee (BCC), chaired by the Chief of Psychology, and co-chaired by the	**Current findings on previous recommendations:**

	Chief of Psychiatry, to review the Wellness and Recovery Plan and maladaptive behavior(s) of the individuals who have not made timely progress on positive behavior support plans. The Chief of Psychology is responsible for the functions of this committee, together with members of the positive behavior support team (in functions of the committee that relate to individuals under the care of those team members). The committee membership shall include all clinical discipline heads, including the medical director, as well as the clinical administrator of the facility.	**Recommendation 1, October 2007:** Schedule regular meetings and ensure that all standing members of the BCC attend the meetings regularly. **Findings:** This monitor's documentation review and interview of the Chief of Psychology found that the Behavioral Consultation Committee (BCC) has been conducting regular bi-weekly meetings, except for the months of November and December 2007 and February 2008. There was only one meeting in November 2007 and February 2008, and no meeting was held in December 2007. The Executive Director, Jon De Morales, has impressed upon the BCC team members the importance of the BCC and the need for its proper functioning through a memo dated August 14, 2007. Furthermore, ASH has identified 13 core members to the BCC whose attendance is required. This monitor's review of the BCC attendance record found that attendance across the BCC meetings held between September 1, 2007 and February 28, 2008, ranged between 35% and 70%. The attendance of the 13 core members to these same meetings ranged between 31% and 69%. **Recommendation 2, October 2007:** Include PBS team members and WRPT members at BCC team meetings to problem-solve as to why plans are not fully implemented. **Findings:** This monitor's document review and interview of the Chief of Psychology found that PBS/DCAT leaders are always present and WRPT members are invited to the BCC team meetings. A number of PBS/DCAT member also form part of the 13-person core BCC

		membership, which includes the heads of disciplines, the Medical Director, and the Clinical Administrator. **Recommendation 3, October 2007:** Set up a system of accountability to ensure that BCC plans are properly implemented when indicated. **Findings:** This monitor's interview of the Chief of Psychology found that ASH has decided to maintain the same policy of having the PBS/DCAT members monitor the BCC plans. However, there were no referrals to the BCC over the last six months. The BCC and PBS/DCAT groups have to be more vigilant on addressing this issue as the number of cases with severe maladaptive behaviors in the facility, as evidenced by the trigger documentation, is high. **Compliance:** Partial. **Current recommendations:** 1. Schedule regular meetings and ensure that all standing members of the BCC attend the meetings regularly. 2. Ensure that BCC plans are properly implemented when indicated.
F.2.f	Each State Hospital shall ensure that it has sufficient neuropsychological services for the provision of adequate neuropsychological assessment of individuals with persistent mental illness.	**Current findings on previous recommendation:** **Recommendation 1, October 2007:** Make referrals, when appropriate, for neuropsychological assessments. **Findings:** This monitor's documentation review and interview of Christine Mathiesen found that the Neuropsychological Service at ASH has been training staff to facilitate appropriate referrals for Neuropsycho-

		logical evaluations and services. The Neuropsychological Services team has put out an excellent course outline (ASH Neuropsychological Services Overview, Course Outline v.3) that should be easily understood by participants in understanding the services and on making appropriate Neuropsychology referrals. Training/meetings have been held with WRPT members (March 18, 2008), Unit Supervisors (August 2007) and Program IV Psychologists (September, 2007). In addition, handouts had been sent via email to physicians, psychologists, social workers, nurse practitioners, rehabilitation therapists, special education teachers and Speech/Language contractors. The Neuropsychology Service has arranged to receive all Neurology Consult reports and hold regular meetings with the neurologist (John Coyle, MD). In addition, information from the Integrated Psychology Assessments: Psychology Section is used to determine individuals who are in need of Neuropsychological Assessments. Referrals for Neuropsychological evaluations are made to the Neuropsychological Service using the ASH/DMH referral form MH 5722. **Recommendation 2, October 2007:** Ensure that neuropsychologists provide cognitive remediation and cognitive retraining groups in the PSR Mall. **Findings:** According to Christine Mathiesen, Neuropsychologists are not providing cognitive remediation and cognitive retraining groups in the PSR Mall due to staffing shortage and the Psychology Departments decision to shift psychology staff to complete the Integrated Assessments (Psychology Section), a move that also resulted in the Neuropsychological Service not conducting Neuropsychological evaluations, especially from December 2007 into March 2008.

Recommendation 3, October 2007:
Increase the number of neuropsychologists to meet the anticipated demand for neuropsychological services.

Findings:
This monitor's review of Neuropsychological referrals, response time to referrals, and PSR services provided by the Neuropsychological Service indicated that ASH lacks the required number of Neuropsychologists to provide full and timely evaluation and services to all individuals in the facility. The Neuropsychology Service has three Neuropsychologists at this time to serve a few hundred individuals at any one time. ASH has two vacant Neuropsychologist slots for which it is actively recruiting. In addition, the Neuropsychological Service is also hoping to secure enough office space to conduct evaluations with the addition of newly hired Neuropsychologists.

ASH used item #19 from the DMH Psychology Services Monitoring Form (see below) to evaluate the turn-around time for Neuropsychological referrals, reporting 32% compliance. The table below showing the number of individuals requiring Neuropsychological services (N), the number of individuals referred for Neuropsychological Services per month (n), and the percentage of referrals completed within 60 days (%C) is a summary of the facility's data.

Each State Hospital shall ensure that it has sufficient neuropsychological services for the provision of adequate neuropsychological assessment of individuals with persistent mental illness.

	Sep	Oct	Nov	Dec	Jan	Feb	Mean
N	11	10	13	0	27	13	
n	11	10	13	0	27	13	
%S	100	100	100	0	100	100	

		%C #19 | 27 | 90 | 46 | 0 | 3 | 23 | 32 **Compliance:** Partial. **Current recommendations:** 1. Make referrals, when appropriate, for neuropsychological assessments. 2. Ensure that neuropsychologists provide cognitive remediation and cognitive retraining groups in the PSR Mall. 3. Increase the number of neuropsychologists to meet the anticipated demand for neuropsychological services.
F.2.g	All clinical psychologists with privileges at any State Hospital shall have the authority to write orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Ensure that this authority is fully approved and implemented. **Findings:** This monitor's documentation review and interview of the Chief of Psychology found that the authority for psychologists to write orders for the implementation of positive behavior support plans, consultation for educational or other testing, and positive behavior support plan updates has been approved. Accordingly, the Department of Psychology has revised its policies and procedures to reflect the changes, and the Medical Executive Committee has approved the changes in the documents. According to the Chief of Psychology, a working group comprised of the Chairs of Psychiatry and Psychology and the Senior Psychologists is developing a training protocol for order-writing. **Compliance:** Partial.

		Current recommendations: Ensure that this authority is fully approved and implemented

3. Nursing Service		
	Each State hospital shall provide adequate and appropriate nursing care and services consistent with generally accepted professional standards of care to individuals who require such services.	**Methodology:** Interviewed: 1. Cynthia Davis, Nurse Administrator Central Nursing Services 2. Vickie Vinke, Health Services Specialist Central Nursing Services 3. Donna Hunt, Health Services Specialist 4. Concha Silva, RN Standards Compliance 5. Jeannine Doolin, RN Standards Compliance 6. Belinda Roetker, RN Standards Compliance Reviewed: 1. ASH's progress report and data 2. Nursing Triggers and Shift Change audit tool 3. DMH Nursing Services Monitoring form and instructions 4. ASH Medication Certification & Recertification Objectives and curriculum 5. ASH NP 307.0, Administration of Medication and Treatments effective 3/7/08; NP 307.0.1, Documentation of Medication and Treatments effective 10/3/07; NP 218.0, Shift Change Communication and Primary Contact Assignments effective (pilot) 3/17/08; NP 203.0, Nursing Assessments-Pilot effective 3/1/08 6. Restraint and Seclusion Documentation curriculum 7. Memo date 1/14/08 regarding Medication Certification & Re-Certification Training changed to annual from bi- annual 8. Training curriculum for RN Significant Change in Condition Assessment Note and form 9. HSS Committee minutes for 2/25/08 10. Nursing Coordinators Meeting minutes for 2/27/08 11. April 2008 Medication Administration Records and Narcotic Log Sign-In sheets for Units 3, 5, 9, 11, 14, 16, 17, 25, 28, and 29 12. The medical records for the following 71 individuals: AAA, AB, AD, AH, AHS, AJ, AJB, ALJ, ALW, AR, AWB, BBA, BG, BLB, BWM, CM,

		CRA, CTS, CW, DDM, DEB, DKL, DLB, DLM, DPC, DRK, DVL, ED, FA, GEG, GKR, GRF, HTK, HVA, JAM, JC, JCA, JDP, JGC, JH, JJL, JKT, JLA, JMM, JOJ, JRF, JS, KFB, LEB, MAM, MDK, MG, MIM, MJC, MM, MP, MR, MSM, PAP, PRI, RCV, RD, RM, TDR, TH, TJS, VA, VMH, WJH, WST and ZDS Observed: 1. Medication pass on an admission unit 2. Shift report on Unit 7 3. Two WRPTs on Program IV
F.3.a	Each State hospital shall develop and implement policies and protocols regarding the administration of medication, including pro re nata ("PRN") and "Stat" medication (i.e., emergency use of psychoactive medication), consistent with generally accepted professional standards of care, to ensure:	**Compliance:** Partial.
F.3.a.i	safe administration of PRN medications and Stat medications;	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Continue to monitor this requirement. **Findings:** ASH's data from the DMH Nursing PRN audit based on a 18% mean sample of number of behavioral PRNs administered per review month (N) from January and February 2008 indicated 97% compliance with the requirement that a PRN was administered based on a complete physician's order and that the nurse administered the correct medication, correct dose, to the correct individual by the correct route at the correct time and date, indicating safe administration of PRN medications.

		ASH's data from the DMH Nursing Stat audit based on a 23% mean sample of number of behavioral Stats administered per review month (N) from January and February 2008 indicated 91% compliance with the requirement that a Stat was administered based on a complete physician's order and that the nurse administered the correct medication, correct dose, to the correct individual by the correct route at the correct time and date, indicating safe administration of Stat medications. **Recommendation 2, October 2007:** Implement monitoring on additional units. **Findings:** ASH has initiated hospital-wide monitoring January 1, 2008 regarding this requirement. **Current recommendations**: Continue to monitor this requirement.
F.3.a.ii	documentation of the circumstances requiring PRN and Stat administration of medications;	**Current findings on previous recommendation:** **Recommendation 1, October 2007:** Provide interactive training regarding policies and procedures relating to PRN and Stat medications. **Findings:** ASH adequately revised the Medication Certification and Re-Certification class objectives to include correct documentation of routine, PRN, Stat and emergency medication and a practicum. ASH's progress report indicated that at the time of this review, 10% of the 873 nursing staff received PRN/Stat documentation training in February 2008 while the remaining 90% will be trained by July 1, 2008.

		Recommendation 2, October 2007: Provide data regarding policy and procedure revisions reflecting this requirement. **Findings:** ASH has adequately revised NP 307.0, 307.01 to include specific direction regarding documentation for PRN, Stat and emergency medications. **Recommendation 3, October 2007:** Continue to monitor this requirement. **Findings:** ASH's data from the DMH Nursing PRN audit based on an 18% mean sample of behavioral PRNs administered per review month (N) from January and February 2008 indicated 15% mean compliance with the requirement that there was documentation of the circumstances requiring PRN administration of medications. ASH's data from the DMH Nursing Stat audit based on a 23% mean sample of behavioral Stats administered per review month (N) from January and February 2008 indicated 9% compliance with the requirement that there was documentation of the circumstances requiring Stat administration of medications. This monitor's review of 50 incidents of PRNs from 12 individuals' medical records (AAA, AD, AJ, ALJ, AWB, BG, DPC, FA, GRF, HVA, JJL and MJC) found that 12 had adequate documentation regarding this requirement. This monitor's review of 50 incidents of Stats from 13 individuals' medical records (AD, AJ, ALJ, BWM, CRA, HTK, JS, MR, PAP, TDR,

		TJS, WST and ZDS) found that 18 had adequate documentation regarding this requirement. As noted during the last review, this monitor found several cases in the IDNs regarding PRN and Stat medication that did not include the name of the medication given, the time it was given, the route, the location if given by injection and who actually administered the medications. In addition, many of the Stat medications were documented in the IDNs as PRNs. This monitor's discussion with Nursing confirmed that ASH uses a medication nurse to administer all the medications during the shift, including PRNs and Stats. However, it is usually the unit nursing staff that determine when an individual warrants a PRN and/or Stat medication, not the medication nurse. Consequently, much of the documentation regarding PRN and Stat medications is done by the medication nurse, not the nurse who assessed the individual. This system appears to contribute to the inadequate documentation found in the progress notes regarding PRN and Stat medications. ASH's progress report indicated that to address this issue, the facility has implemented the use of a prompt card, which has been placed on each unit and includes PRN/Stat documentation requirements. In addition, the Restraint and Seclusion Documentation class includes training regarding the documentation of PRNs and Stats. In March 2008, ASH revised the medication certification/recertification class, which is required annually and includes every-five-month medication competency validations. Clearly, the significant issues regarding the documentation of PRN and Stat medications need prompt attention. **Current recommendations**: 1. Continue to implement training and competency validation regarding this requirement.

		2. Continue to monitor this requirement.
F.3.a.iii	documentation of the individual's response to PRN and Stat medication.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Continue to monitor this requirement. **Findings:** ASH's data from the DMH Nursing PRN audit based on an 18% mean sample of number of behavioral PRNs administered per review month (N) from January and February 2008 indicated 18% compliance with the requirement that there was documentation of the individual's response to the PRN medication. ASH's data from the DMH Nursing Stat audit based on a 23% mean sample of number of behavioral PRNs administered per review month (N) from January and February 2008 indicated 22% compliance with the requirement that there was documentation of the individual's response to the Stat medication. This monitor's review of 50 incidents of PRNs from 12 individuals' medical records (AAA, AD, AJ, ALJ, AWB, BG, DPC, FA, GRF, HVA, JJL and MJC) and of 50 incidents of Stats from 13 individuals' medical records (AD, AJ, ALJ, BWM, CRA, HTK, JS, MR, PAP, TDR, TJS, WST and ZDS) found that in most cases it was difficult if not impossible to determine from the IDNs when the PRN and/or Stat was actually given in order to find documentation of the individual's response. The documentation on the medication administration records only stated "helpful or not helpful" in most of the cases. **Current recommendations**: See F.3.a.i.

F.3.b	Each State hospital shall ensure that all failures to properly sign the Medication Treatment Record (MTR) or the controlled medication log are treated as medication variances, and that appropriate follow-up occurs to prevent recurrence of such variances.	**Current findings on previous recommendation:** **Recommendation 1, October 2007:** Provide data reflecting this requirement. **Findings:** ASH's data indicated that a medication variance report was completed for 195 failures to properly sign the Medication Treatment Record (MTR) or the controlled medication log from September 2007-February 2008 on Program IV. **Recommendation 2, October 2007:** Continue to expand monitoring of this requirement to additional units. **Findings:** ASH's progress report indicated that additional units will be added to the monitoring of this requirement in alignment with the EP roll-out and that the Health Services Specialists will complete the training regarding the medication variance reporting for the additional programs by August 1, 2008. Since this issue is related to safe medication practices, this monitor recommends that the facility not wait to implement this system in conjunction with the roll-out of the Wellness and Recovery Model. Procedures ensuring safe medication practices and the accurate and reliable collection of data regarding medication variances are associated with generally accepted standards of nursing practice and need to be implemented facility-wide. **Recommendation 3, October 2007:** Continue to monitor this requirement.

		Findings: Same as above. **Other findings:** This monitor's review of the April 2008 Narcotic Sign-In sheets and the Medication Administration Records (MAR) from units 3, 5, 9, 11, 14, 16, 17, 25, 28 and 29 found blanks on the Narcotic Sign-In sheets for units 5 and 28, and MAR blanks for units 16, 17 and 25. However, since the medication variance reporting system has only been implemented on Program IV, none of these omissions had an associated medication variance report. **Compliance:** Partial. **Current recommendations**: 1. Implement the medication variance reporting system facility-wide. 2. Continue to monitor this requirement.
F.3.c	Each State hospital shall ensure that all nursing interventions are fully integrated into the therapeutic and rehabilitation service plan and that nursing interventions are written in a manner aligned with the rest of the interventions in the therapeutic and rehabilitation service plan, in particular, in observable, behavioral, and/or measurable terms. No nursing care plans other than the nursing interventions integrated in the therapeutic and rehabilitation service plan are required. No nursing diagnoses other than as specified in the therapeutic and rehabilitation service plan, in terms of the current DSM criteria, are required.	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Provide data regarding competency related to WRP and the Recovery Model. **Findings:** ASH's data from the WRP Competency-Based Training audit for December 2007-February 2008 indicated 14% mean compliance with the requirement that existing nursing staff that required WRP competency-based training per review month actually received the training and 80% mean compliance for newly hired staff. ASH reported that the low numbers of nurses attending the WRP Competency-Based Training was due to issues with staffing vacancies, inability to provide

		coverage on the units to ensure the individuals' safety, and to provide coverage during the WRPCs. **Recommendation 2, October 2007:** Ensure that interventions are written in observable, behavioral, and/or measurable terms. **Findings:** ASH's progress report indicated that a two-hour mandatory care plan training for nursing staff was to be implemented and completed by July 1, 2008. **Recommendations 3 and 4, October 2007:** • Develop and implement a system to monitor and track the implementation of interventions. • Continue to develop and implement proactive interventions related to individuals' needs. **Findings:** ASH's data from the DMH Nursing Interventions audit (December 2007-February 2008) based on a 58% mean sample of WRPs scheduled per review month indicated 79% mean compliance with the requirement that there are interventions (therapeutic milieu and active treatment, if applicable) specific as to how nursing is going to assist the individual in meeting his or her goals for each open focus; 64% mean compliance with the requirement that nursing interventions are written in observable terms; 12% mean compliance with the requirement that nursing interventions are written in behavioral and/or measurable terms; and 99 % mean compliance with the requirement that only the approved DMH WRP forms are used and that there are no Nursing Diagnosis (NANDA) statements in the WRP. (Data represents only Program IV.)

		This monitor's review of 40 individuals' WRPs (AB, AH, AHS, AJB, AR, BLB, CM, DEB, DKL, DLB, DLM, DRK, DVL, ED, GEG, JAM, JC, JCA, JDP, JGC, JH, JJL, JKT, JLA, JMM, JOJ, JRF, KFB, MAM, MG, MIM, MM, MP, MSM, PRI, RM, TH, VA, VMH and WJH) found basically no improvement in this area since the last review at ASH. Many of the nursing objectives/interventions were inadequate or inappropriate for the individual's cognitive status. As found in the last review, several interventions stated "give medications as ordered." In many cases, information contained in the nursing admission/integrated assessments regarding an individual's interests, past issues, coping strategies or stress relievers were not included in the WRPs. If education was provided as stated in the WRP, there was no documentation that it was actually taking place as often as the WRP indicated or documentation that contained an assessment of the individual's response to the education. Contrary to ASH's data, there were few to no proactive nursing interventions in the WRPs. Based on discussions with the auditors for this section, it appears that the compliance scores were based merely on the presence of objectives and interventions rather than on quality and appropriateness. **Recommendation 5, October 2007:** Develop and implement a monitoring instrument and tracking system addressing this requirement. **Findings:** The DMH Nursing Interventions audit has been initiated by the facility, addressing this recommendation. **Other findings:** ASH provided data regarding nursing interventions. However, it was agreed that the nursing objectives, rather than interventions, should be monitored regarding observable, behavioral, and/or measurable terms.

		Compliance: Partial. **Current recommendations**: 1. Increase the number of existing staff's attendance at the WRP Competency-Based training. 2. Implement mandatory care plan training. 3. Include quality and appropriateness in the auditing criteria regarding WRPs. 4. Continue to monitor this requirement.
F.3.d	All nursing staff working with an individual shall be familiar with the goals, objectives and interventions for that individual.	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Expand monitoring to additional units. **Findings:** ASH's progress report indicated that the monitoring for this requirement will be implemented on all units on April 1, 2008. **Recommendation 2, October 2007:** Continue to monitor this requirement. **Findings:** ASH's data from the DMH Nursing Staff Familiarity audit for February 2008 based on an 87 % sample of licensed nursing staff on the AM/PM shift indicated 51% compliance with the requirement that nursing staff working with an individual was familiar with the goals, objectives and interventions for that individual. (Data represents only Program IV.) ASH has implemented a pilot that includes a review of goals, objectives and interventions for some individuals during shift change. However, from this monitor's observations of this process, it

		appeared to be more of a task than a process to become familiar with an individual's goals and objectives. Unfortunately, the staff observed made inappropriate comments about the likelihood of the individual achieving the WRP goals rather than discussing modifications that would have increased his success. **Compliance:** Partial. **Current recommendations**: 1. Implement monitoring of this requirement on other units as planned. 2. Continue to monitor this requirement.
F.3.e	Each State hospital shall ensure that nursing staff timely monitor, document and report the status of symptoms, target variables, health, and mental health status, of individuals in a manner that enables interdisciplinary teams to assess each individual's status, and response to interventions, and to modify, as appropriate, individuals' therapeutic and rehabilitation service plans. Each State Hospital shall ensure that all nursing shift changes include a review of changes in status of individuals on the unit.	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Re-train nursing regarding assessment skills and required documentation for acute changes in status. **Findings:** ASH's progress report indicated that the HSSs began training regarding this recommendation on March 1, 2008. In addition, ASH has developed and implemented a new RN Change in Condition Assessment Note on March 1, 2008 that prompts staff to include pertinent information. **Recommendation 2, October 2007:** Re-train psychiatric technicians as to when nursing should be notified regarding changes in status. **Findings:** ASH reported the informal training will be provided (read and sign) for

		the psychiatric technicians by May 30, 2008, addressing this recommendation. **Recommendation 3, October 2007:** Ensure that documentation guidelines/protocols specify criteria regarding acute changes in status, closure of problems, notification of physicians, and ER visits/hospitalizations. **Findings:** ASH appropriately revised NP 203 in March 2008 and implemented the RN Significant Change in Conditions Assessment Note that includes instructions for summarizing outside facility care and treatments and for notification of physicians that includes name, date and time. **Recommendation 4, October 2007:** Ensure that staff clearly document their titles in the progress notes. **Findings:** ASH reported that training regarding this recommendation is ongoing. **Recommendation 5, October 2007:** Implement a system to track and monitor acute changes in status. **Findings:** ASH has implemented the use of the Physical Health Key Indicator (PHKI) list, which replaced the risk indicator profile previously used. **Recommendation 6, October 2007:** Revise current Change in Status monitoring form to reflect appropriate standards of nursing practice. **Findings:** ASH's progress report indicated that a new monitoring tool was

implemented January 1, 2008. However, this monitor did not find the tool included in the supporting documents to review.

Recommendation 7, October 2007:
Revise Nursing Policy 218.0 regarding Shift Report to include elements of the WRP information.

Findings:
ASH has adequately revised NP 218.0 to include elements of the WRP information.

Recommendation 8, October 2007:
Implement shift report monitoring.

Findings:
ASH's data from the DMH Nursing Triggers and Shift Change audit based on a 70% mean sample of target triggers that fired per review month (N) for December 2007-February 2008 indicated the following mean compliance score for each listed item:

1.	*If the individual reported symptoms, in the IDN there is documentation of timely (based on the severity of the symptoms) notification by the nursing staff to the physician.*	88%
1.a	*If the individual reported emergent symptoms, there is documentation in the IDN of immediate notification by the nursing staff to the physician.*	81%
1.b	*If the individual reported urgent symptoms, there is documentation in the IDN of notification within one hour by the nursing staff to the physician.*	85%
2.	*In the IDN there is an appropriate identification of the change in the individual's condition, which includes:*	46%
2.a	*Vital signs.*	44%

		2.b	*All other clinically indicated areas*	59%
		3.	*In the IDN there is documentation of when the change in the individual's status occurred.*	92%
		4.	*In the IDN there is documentation of when the physician was notified and the physician's name.*	14%
		5.	*If the individual was transferred from the DMH hospital to an acute medical facility, there is documentation in the IDN of the transfer, which includes:*	100%
		5.a	*The reason for the transfer.*	100%
		5.b	*The identity of the facility to which the individual was transferred.*	100%
		5.c	*The date and time of the transfer.*	100%
		6.	*The nursing staff reports to the oncoming shift the target variable that the individual exhibited.*	61%
		7.	*The nursing staff discusses with the oncoming shift the specific interventions for the individual, including the appropriate continuum of care across shifts.*	61%
		Observations of shift report on Unit 7 revealed that there was a significant lack of clinical information contained in the report. A situation with an individual being in the bathroom at the time points were documented on the point card was described by staff as the individual purposely seeking confrontation. However, during the conversation, another staff member indicated that the individual had dementia, which seemed to conflict with the perception of him being purposefully confrontational. Without any further analysis of the behavior, it was decided by staff that the individual was manipulative. In addition, a number of comments made by the staff were inappropriate and demonstrated a considerable lack of understanding of Wellness and Recovery. Unfortunately, this unit was touted as the model unit for conducting shift reports.		

		Other Findings: This monitor reviewed the charts of 10 individuals (ALW, BBA, CTS, CW, DDM, GKR, LEB, MDK, RCV and RD) who required emergency medical care. Below is a summary of findings: 1. An individual was seen at the community hospital for fever, urinary tract infection (UTI) and hypotension on 1/9/08. Issues included: a. Significant lack of vital signs taken and documented related to poor intake and output since 1/7/08. b. Intake and output not totaled on flow sheets for 1/7, 1/8, 1/9 and 1/11. c. Lack of response by nurse on duty (NOD), "shift lead called NOD four times." d. Conflicting documentation regarding results of catheterization on 1/8/08. e. No vital signs or assessment documented when result of catheterization was dark urine and complaints of abdominal pain. f. No summary of signs and symptoms regarding the need for starting fluids intravenously (IV). g. Progress note on 1/9/08 only noted vital signs normal without documenting specific values for baseline. h. Documentation of PRN of Ativan given on 1/9/08 did not include route and follow-up. i. No assessment or vital signs documented in progress note indicating "bright red urine." j. No status documented prior to transfer to hospital. k. Documentation upon return indicated creamy liquid dripping/running from both eyes. No subsequent documentation found. 2. An individual was seen at the community hospital for chest pain on 12/13/07. Issues included:

		a. Progress note on 12/9/08 indicated he got up to get medication for pain. However, no documentation of the medication and assessment of pain were found. b. Assessment note regarding chest pain on 12/13/07 was very thorough; it was unclear from the note if the individual actually went to the hospital. c. No documentation of status prior to transfer to hospital. d. No summary of hospitalization and treatment provided documented upon his return to ASH. 3. An individual was seen at the community hospital for altered mental status on 11/1/07. Issues included: a. No regular mental status assessments documented. Progress notes only indicated confusion. b. Progress note indicated he slept in clothes and shoes. However, notes indicated that he needed staff assistance for activities of daily living. 4. An individual was seen at the community hospital for a seizure on 11/16/07. Issues included: a. Good description of seizure and status afterwards in progress notes. b. Inadequate mental status assessments that only included orientation questions, not others such as who is president, what is the year, etc. c. No neuro checks done on an individual who had his first seizure and no history of seizures. 5. An individual was seen at the community hospital to rule out myocardial infarction on 11/21/07. Issues included: a. Vital signs not consistently taken when he complained of chest pain and received nitroglycerin sublingually. b. Late entry for 0200 documented at 2230 regarding episode

		of chest pain. c. Physician not timely notified of symptoms. d. Dosage and route of nitroglycerin and Ativan not documented. e. Progress note indicated PRN given for pre-chest pain feeling. No medication, dose, route or follow-up documented. f. Lung congestion noted on 11/21/07. No follow-up documentation. 6. An individual was seen at the community hospital for abdominal pain on 12/22/07. Issues included: a. Progress notes out of order. b. Note on 12/21/07 indicated he had felt poorly with nausea all day. However, no assessment or no vital signs documented. c. No documentation of status updates while hospitalized from 12/22/07-12/29/07. d. No summary of hospitalization and treatment provided documented upon his return to ASH. 7. An individual was seen at the infirmary for pneumonia on 12/13/07. Issues included: a. Progress notes for 9/30/07 not found. b. No documentation of lung sounds or vital signs for episode of coughing. 8. An individual was seen at the community hospital for seizures and critical labs 2/7/08. Issues included: a. Some progress notes difficult to read. b. Thorough documentation of seizure activity. c. No nursing assessment documented prior to leaving ASH for the hospital. d. No vital signs documented prior to transfer. e. No documentation of status updates while hospitalized. f. No summary of hospitalization and treatment provided

		documented upon his return to ASH. 9. An individual was seen at the infirmary to rule out a head injury on 1/14/08. Issues included: a. No assessment or vital signs documented when RD was first found with injuries. b. Documentation indicated vital signs stable without specific values for baseline. c. Only one set of neuro checks documented the day after the injury. 10. An individual was seen at the infirmary for to rule out bowel obstruction 2/2/08. Issues included: a. No vital signs for episodes of vomiting brown fluid and coffee-ground emesis. b. No documentation of routine bowel sounds. c. Progress notes out of order. **Compliance:** Partial. **Current recommendations**: 1. Ensure that nursing staff are documenting adequate assessments of individuals prior to and upon return from ER visits or hospitalizations. 2. Continue to monitor this requirement.
F.3.f	Each State hospital shall develop and implement a system to monitor nursing staff while administering medication to ensure that:	**Compliance:** Partial.
F.3.f.i	nursing staff are knowledgeable regarding each individual's prescribed medications;	**Current findings on previous recommendations:**

		Recommendation 1, October 2007: Implement observations of existing staff regarding medication administration competency. **Findings:** On February 1, 2008, ASH initiated the medication competency observations for the every-five-month process. **Recommendation 2, October 2007:** Continue to monitor this requirement. **Findings:** ASH's data from the DMH Nursing Medication Administration audit for February 2008 based on a 6% sample of nursing staff that have Medication Certification (N) indicated 89% compliance with the requirement that nursing staff are knowledgeable regarding each individual's prescribed medication. **Current recommendations**: 1. Increase sample size audited for this requirement. 2. Continue to monitor this requirement.
F.3.f.ii	education is provided to individuals during medication administration;	**Current findings on previous recommendation:** **Recommendation 1, October 2007:** Implement a process to ensure privacy during medication administration to facilitate medication education. **Findings:** ASH's progress report indicated that the physical design of the units would require changes beyond the current capacity of the facility to adequately address this recommendation. However, they did report that NP 307 will be revised to include, "The medication assist person

		will assure that only one individual is at the medication window at a time" to facilitate privacy for medication education. **Recommendation 2, October 2007:** Expand medication administration observations to additional units. **Findings:** ASH has begun hospital-wide medication administration observations on February 1, 2008, addressing this recommendation. **Recommendation 3, October 2007:** Continue to monitor this requirement. **Findings:** ASH's data from the DMH Nursing Medication Administration audit for February 2008 based on a 6% sample of nursing staff that have Medication Certification (N) indicated 78% compliance with the requirement that education is provided to individuals during medication administration. **Current recommendations**: Same as F.3.f.i.
F.3.f.iii	nursing staff are following the appropriate medication administration protocol; and	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Expand monitoring of this requirement. **Findings:** See F.3.f.ii, Recommendation 2. **Recommendation 2, October 2007:** Continue to monitor this requirement.

		Findings: ASH's data from the DMH Nursing Medication Administration audit for February 2008 based on a 6% sample of nursing staff that have Medication Certification (N) indicated 100% compliance with the requirement that nursing staff are following the appropriate medication administration protocol. **Current recommendations:** Same as F.3.f.i.
F.3.f.iv	medication administration is documented in accordance with the appropriate medication administration protocol.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Same as F.3.f.iii. **Findings:** ASH's data from the DMH Nursing Medication Administration audit for February 2008 based on a 6% sample of nursing staff that have Medication Certification (N) indicated 98% compliance with the requirement that medication administration is documented in accordance with the appropriate medication administration protocol. **Other findings:** In observations of medication administration pass, this monitor noted that there was minimal education provided to individuals and little to no involvement of the individual in issues such as blood sugar monitoring associated with the individual's activities and medications. Although the staff member observed knew about the medications that he was administering and appeared to have a good rapport with the individuals during medication administration, there was little meaningful interaction during the medication pass process.

		Current recommendations: Same as F.3.f.i.
F.3.g	Each State hospital shall ensure that individuals remain in a "bed-bound" status only for clinically justified reasons.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Continue to monitor this requirement. **Findings:** There were no "bed-bound" individuals during the reporting period. However, as noted in the last report, ASH has the DMH Bed Bound Individuals Monitoring Form in the event that an individual becomes bed-bound. **Compliance:** Not applicable. **Current recommendations**: Continue to monitor this requirement in the event this issue occurs.
F.3.h	Each State hospital shall ensure that, before they work directly with individuals, all nursing and psychiatric technicians have successfully completed competency-based training regarding:	**Compliance:** Partial.
F.3.h.i	mental health diagnoses, related symptoms, psychotropic medications and their side effects, monitoring of symptoms and target variables, and documenting and reporting of the individual's status;	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Provide nursing training regarding the assessment, documentation, and reporting of changes in status. **Findings:** See findings for Recommendation 1 in F.3.e.

		Recommendation 2, October 2007: Continue to monitor this requirement. **Findings:** ASH's data from the New Employee Medication Certification Competency-Based Training audit (September 2007-February 2008) based on a 100% sample indicated 89% mean compliance with the requirement that new staff received competency-based training regarding psychotropic medications and their side effects, monitoring of symptoms and target variables. In addition, ASH's data from the New Employee Nursing Assessment Training for the same time period based on a 100% sample of newly hired nursing staff that required the training per review month (N) indicated 83% mean compliance with the requirement that staff received competency-based training regarding documenting and reporting of the individual's status. ASH's progress report indicated that there was no data regarding mental health diagnoses and related symptoms this review period since the class had just begun on March 1, 2008. No data was provided for existing staff training regarding this requirement. **Current recommendations**: 1. Provide data for existing staff training regarding this requirement. 2. Continue to monitor this requirement.
F.3.h.ii	the provision of a therapeutic milieu on the units and proactive, positive interventions to prevent and de-escalate crises; and	**Current findings on previous recommendation:** **Recommendation, October 2007:** Continue to monitor this requirement.

		Findings: ASH's data from the Therapeutic Milieu Competency-Based Training audit (September 2007-February 2008) based on a 100% sample of nursing staff that required the competency-based training per review month (N) indicated 9% mean compliance with the requirement that staff received training on the provision of a therapeutic milieu on the units. ASH reported that the low compliance was due to staffing vacancies that did not permit staff to be off the units for training and the need to provide coverage in the WRPTs. ASH's data from the New Employee PMAB in Recovery Competency-Based Training audit indicated that all 47 newly hired employees from September 2007-February 2008 received training in proactive, positive interventions to prevent and deescalate crises. No data was provided regarding existing staff. **Current recommendations**: Same as F.3.h.i.
F.3.h.iii	positive behavior support principles.	**Current findings on previous recommendation:** **Recommendation 1, October 2007:** Ensure that all staff attend the entire PBS competency-based training. **Findings:** ASH's progress report indicated that in addition to the abbreviated two-hour class, an additional six hours of training began on March 1, 2008. However, it was unclear if staff who only attended the two-hour class would also receive the additional hours of training.

		Recommendation 2, October 2007: Accurately track and monitor attendance for PBS training. **Findings:** No data was provided regarding this recommendation. **Recommendation 3, October 2007:** Continue to monitor this requirement. **Findings:** ASH reported that 89% of 47 newly hired employees received the required training for positive behavior support principles from September 2007-February 2008. **Other findings:** No data was provided regarding existing staff training. **Current recommendations**: Same as F.3.h.i.
F.3.i	Each State hospital shall ensure that, prior to assuming their duties and on a regular basis thereafter, all staff responsible for the administration of medication has successfully completed competency-based training on the completion of the MTR and the controlled medication log.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Same as F.3.f.iii. **Findings:** ASH's data from the New Employee Medication Certification Competency-Based Training audit (September 2007-February 2008) based on a 100% sample of nursing staff that required the competency-based training per review month (N=47) indicated 89% mean compliance with the requirement that prior to assuming their duties, all staff responsible for the administration of medication had successfully completed competency-based training on the completion of the MTR

		and the controlled medication log. No data was provided regarding training for the existing staff. **Other findings:** ASH's progress report indicated that effective March 1, 2008, the re-certification class is conducted annually rather than bi-annually. **Compliance:** Partial. **Current recommendations**: Same as F.3.h.i.

4. Rehabilitation Therapy Services		
	Each State hospital shall provide adequate, appropriate, and timely rehabilitation therapy services to each individual in need of such services, consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. Ladonna DeCou, Chief of Rehabilitation Therapy 2. Rachelle Rianda, Acting Supervising Rehabilitation Therapist 3. Terry Devine, Physical Therapist (contract) 4. Meg Benitez, Physical Therapist (contract) 5. Elizabeth Price, Speech Language Pathologist (contract) 6. Carrie Dorsey, Music Therapist, Interacting Through Music PSR Mall Group Facilitator 7. Angela McGregor, Recreation Therapist, Arts and Crafts PSR Mall Group Facilitator 8. Joshua Goible, Recreation Therapist, Physical Wellness and Exercise PSR Mall Group Co-facilitator 9. Heather Grigsby, Recreation Therapist, Gym PSR Mall Group Facilitator 10. Ai Fujimoto, Recreation Therapist, Basic Interpersonal Task Skills PSR Mall Group Co-facilitator 11. Mark Ferris, Recreation Therapist, Competency Through Activities PSR Group Facilitator 12. The following individuals participating in Rehabilitation Services group or direct treatment: DM and JH Reviewed: 1. DMH Rehabilitation Therapy Service Manual 2. ASH Mall Course Schedule for week of review 3. Speech and Physical Therapy direct treatment schedule for week of review 4. Memorandum: Required Hours for Mall Facilitators (dated 1/15/08) 5. Adaptive Equipment database 6. List of individuals with wheelchairs/mobility equipment

		7. List of individuals with adaptive dining equipment 8. Proposed Adaptive Equipment Tracking Report (database) 9. PSR Mall Course Facilitator Consultation form 10. Records for the following 18 individuals participating or enrolled in observed Mall groups: ARC, ARR, CBJ, DJS, DLM, DRR, FRP, GEG, HTK, JAM, LGS, LRT, MA, MAG, MLT, PMJ, SEF and SLM 11. The following approved course outlines developed by Rehabilitation Therapy: Focus on Music, Interacting Through Music, Non-aggressive Communication I, Gospel Choir, Emotion/Stress Management Through Music Exploration, Good Clean Fun, Physical Wellness: Strength and Conditioning 12. The following approved 12-week Lesson Plans developed by Rehabilitation Therapy: Fun with Music, Basic Interpersonal Task Skills, Leisure Education, Problem Solving Through Rehabilitation Therapy 13. Records for the following 19 individuals to compare RIAT Pilot assessments and Integrated Assessments-Rehabilitation Therapy Section with WRP documents: ADS, AL, EO, GAW, GCD, GCJ, JB, JCS, JEP, JES, JSR, KNB, LAP, MJC, MWV, PVH, TDW, THT and VL 14. List of individuals who received direct Physical Therapy services from September 2007- February 2008 15. Records for the following seven individuals who received Physical Therapy assessment/consultation during the September 2007-February 2008 review period to compare assessments and corresponding WRP's: FW, GD, JJ, JPM, LPM, MDH and WST 16. Records for the following eight individuals who received direct Physical Therapy services between September 2007- February 2008: DRD, ECD, FGM, GD, JAG, JH, LPM and RRF 17. Records for the following seven individuals who received Speech Therapy assessment/consultation during the September 2007-February 2008 review period: EVT, JDP, JKC, LAB, RLS, RPD and RSP

		18. Records for the following eight individuals who received direct Speech Therapy services from September 2007- February 2008: JH, JR, MAC, RAC, RDN, RLS, RW and TLG 19. Records for the following 11 individuals who had a Vocational Assessment from September 2007-February 2008: CBC, CSR, DDD, JIL, JKS, LHJ, MWN, PCK, RCH, RDW and RSA <u>Observed</u>: 1. Interacting Through Music Group 2. Arts and Crafts Group 3. Basic Interpersonal Task Skills Group 4. Gym Group 5. Competency Through Activities Group 6. Physical Wellness and Exercise Group 7. The following individuals during Physical Therapy treatment: ECD and JH 8. The following individuals during Speech Therapy treatment: JH and JR
F.4.a	Each State hospital shall develop and implement policies and procedures, consistent with generally accepted professional standards of care, related to the provision of rehabilitation therapy services that address, at a minimum:	**Compliance:** Partial.
F.4.a.i	the provision of direct services by rehabilitation therapy services staff; and	**Current findings on previous recommendation:** **Recommendation 1, October 2007:** Develop and implement a procedure to specify WRPC attendance requirements per discipline, according to individualized needs (e.g., receiving direct treatment).

		Findings: According to facility report and review of procedures, the Unit Psychosocial Rehabilitation Therapists are required to attend all WRPC's on their assigned units as enduring team members. POST Therapists and Vocational Rehabilitation therapists may attend WRPCs when clinically indicated per proposed policy. Psychosocial Rehabilitation Therapists will act as liaisons for the other Rehabilitation Therapy disciplines (Vocational Rehabilitation, Occupational, Physical, and Speech Therapists). **Recommendation 2, October 2007:** Develop and implement a procedure that specifies criteria for the need for and implementation of a 24-hour support plan related to physical and/or nutritional support. **Findings:** This recommendation has not been addressed. Additionally, an integrated individualized plan to provide 24-hour indirect physical and/or nutritional rehabilitation support to minimize risk and maximize independence in all functional domains has not yet been developed. **Recommendation 3, October 2007:** Develop and implement a system by which assessment/consultation findings, recommended supports/objectives and progress toward these objectives can be reported to the WRPT by all Rehabilitation Therapy Services disciplines. **Findings:** According to facility report and review of procedures, the Psychosocial Rehabilitation Therapist reports findings regarding monthly progress toward direct Occupational, Physical, and/or Speech therapy treatment objectives to the WRPT. However, a format for progress note documentation by OT, PT and SLP that is consistent among the state

		hospitals and that meets practice act requirements has not yet been developed. **Recommendation 4, October 2007:** Provide competency-based training to Rehabilitation Therapy staff regarding Recommendation 3. **Findings:** This recommendation has not been addressed; currently competency-based training for Rehabilitation Therapy staff (Rehabilitation Therapists, Vocational Rehabilitation staff and POST team members) regarding the role of the RT as WRPT liaison is pending. **Recommendation 5, October 2007:** Ensure that all Rehabilitation Therapy staff is provided competency-based training on all procedures related to the Psychosocial Rehabilitation Mall. **Findings:** The facility reports that all Psychosocial Rehabilitation Therapists have received training on PSR Mall procedures, but did not provide documentation of this training. The facility reports that POST team therapists and Vocational Rehabilitation staff will be trained on PSR Mall procedures in the future. **Recommendation 6, October 2007:** Develop and implement an audit tool to ensure the adequate and timely provision and implementation of Rehabilitation Services, including direct treatment and indirect supports (e.g., Dining Plan, adaptive equipment), corresponding documentation of supports and progress, and incorporation of objectives and recommendations into the WRP.

		Findings: This recommendation has not been addressed. **Recommendation 7, October 2007:** Establish inter-rater reliability among staff performing audits prior to implementation of all audit tools. **Findings:** This recommendation has not yet been addressed, as the audit tool has not been developed. **Current recommendations**: 1. Develop and implement a procedure that specifies criteria for the need for, format of, and implementation (including training and monitoring) of a 24-hour support plan related to physical and nutritional rehabilitation supports that is consistent among the state hospitals. 2. Develop and implement formats for progress notes for Vocational Rehabilitation, and Occupational, Physical and Speech Therapy direct treatment that are consistent with those at the other state hospitals as well as with individual discipline practice act requirements. 3. Provide training to all Rehabilitation Therapy staff (Rehabilitation Therapists, Vocational Rehabilitation staff, and POST team members) regarding the role of the RT as WRPT liaison. 4. Develop and implement an F.4 audit tool to ensure the adequate and timely provision and implementation of Rehabilitation Services, including direct treatment (1:1 and PSR Mall group) and indirect supports (e.g., 24-hour plan, adaptive equipment). Implementation findings should also include recommendations regarding foci, objectives and interventions made by Rehabilitation Therapy Services, quality of these objectives in regards to Wellness and

		Recovery criteria, documentation of progress towards objectives, modification of objectives/ interventions as needed, and WRP inclusion. 5. Establish inter-rater agreement among staff performing audits prior to implementation.
F.4.a.ii	the oversight by rehabilitation therapists of individualized physical therapy programs implemented by nursing staff.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Develop and implement a plan to ensure oversight and monitoring of Physical Therapy programs implemented by nursing staff. **Findings:** Currently, individualized Physical Therapy plans are not implemented by nursing staff. All plans are carried out as Home Exercise Programs by individuals. However, according to facility report, many individuals are not able to independently implement home programs due to cognitive barriers and non-interest/poor compliance. There is no system in place to ensure that individuals who require assistance by direct care staff to ensure implementation of Physical Therapy home exercise programs occurs, as clinically indicated. There is not currently a database to track individuals who require indirect Physical or Occupational therapy programs, which lists when staff has received competency-based training/return demonstration, and how often the individual should be reassessed by the Physical or Occupational Therapist to determine the continued appropriateness of the program. There is not currently a system in place to provide oversight to program implementation. **Current recommendations**: 1. Develop and implement a procedure for nursing staff provision of indirect Physical and Occupational Therapy programs.

		2. Develop and implement a database to track individuals receiving these services, as well as when staff has received competency-based training/return demonstration, and how often the individual should be reassessed by the Physical or Occupational Therapist to determine the continued appropriateness of the program. 3. Develop and implement an audit tool to provide oversight to individuals receiving Physical or Occupational Therapy programs implemented by nursing staff to assess for appropriateness of program, alignment with assessment/reassessment findings, timeliness of reassessment, and whether program is modified as needed.
F.4.b	Each State hospital shall provide competency-based training to nursing staff, as appropriate, on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Develop and implement a plan to ensure that competency-based training on the use and care of adaptive equipment, transferring and positioning, as well as the need to promote individuals' independence, occurs as needed. **Findings:** This recommendation has not been addressed. There is no system in place to track whether an individual or the staff serving the individual requires competency-based training, as well as when training was provided, with competency scores/return demonstration ability listed. According to facility report, POST team therapists have provided no competency-based training to nursing staff regarding Rehabilitation Therapy supports. **Compliance:** Noncompliance.

		Current recommendations: 1. Develop and implement a plan to ensure that competency-based training on the use and care of adaptive equipment, transferring, and positioning, as well as the need to promote individuals' independence occurs as needed. 2. Ensure that databases for Physical and Occupational Therapy programs implemented by nursing staff, adaptive equipment, 24-hour plans, track the need and provision of competency-based training for individuals and/or staff.
F.4.c	Each State hospital shall ensure that individuals are provided with timely and adequate rehabilitation therapy services.	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Develop and implement a plan to track Rehabilitation Therapy staff attendance at WRPCs as indicated per revised procedure. **Findings:** WRPC attendance by Rehabilitation Therapists is currently done by the Behavior Specialist as part of the team WRP observation. There is currently not a system in place for Rehabilitation Therapists to perform an internal audit of Rehabilitation Therapy attendance at WRPCs. Record review of RIAT Pilot assessments from November-December 2007 and IA-RTS assessments from January-February 2008 showed that RT attendance was noted at 72% of WRPCs as evidenced by attendance rosters reviewed. Upon in-vivo observation of two WRPCs, it was noted that a Rehabilitation Therapists was present at both. **Recommendation 2, October 2007:** Ensure that audit tools monitor for inclusion in the WRP of recommendations/objectives made by Rehabilitation Therapy Services as well as progress towards objectives.

		Findings: This recommendation has not been addressed as the tool has not been developed. **Other findings:** Upon in-vivo observation, it was noted that for four individuals reviewed, Rehabilitation Therapists presented assessment findings to the team to be included in the Present Status section of the WRP in three out of four individual WRPCs, and provided Focus 10 objectives in observable, measurable, and behavioral format for two out of four individual WRPC's. During observation of six PSR Mall groups led by Rehabilitation Therapists, it was noted that two out of six had lesson plans, and both of these lesson plans were in use. Review of a sample of RIAT Pilot assessments and Integrated Assessments-Rehabilitation Therapy Section found that 75% of assessments included recommendation for foci, 33% included objectives and 58% included interventions. Review of corresponding WRPs indicated 58% inclusion of foci, 26% inclusion of objectives and 47% inclusion of recommendations. Review of a sample of Physical Therapy assessments found that none of assessments included WRP recommendation for focus, 43% included objectives and 86% included interventions. Review of corresponding WRPs indicated 43% inclusion of foci, 0% inclusion of objectives and 29% inclusion of recommendations. Review of a sample of Speech Therapy assessments found that 80% of assessments included WRP recommendations for focus, 40% included objectives and all included interventions. Review of corresponding

		WRPs indicated 33% inclusion of foci, 0% inclusion of objectives and 33% inclusion of recommendations. Review of a sample of Vocational Rehabilitation assessments found that 27% of assessments included WRP recommendations for focus, 18% included objectives and 73% included interventions. Review of corresponding WRPs indicated 18% inclusion of foci, 0% inclusion of objectives and 18% inclusion of recommendations. Record review of individuals receiving direct Physical Therapy treatment found that 100% of records contained IDN documentation of progress, but none contained documentation of progress in the WRP. Of the two individuals observed in direct Physical Therapy treatment, both individuals were engaged in activities that aligned with assessment findings and objectives. Upon interview with one of these individuals (JH), it was noted that the individual was aware of his objectives and reported progress and benefits of Physical Therapy direct treatment. Record review of individuals receiving direct Speech Therapy treatment found that 88% of records contained IDN documentation of progress but none contained documentation of progress in the WRP. Of the two individuals observed in direct Speech Therapy treatment, both individuals were engaged in activities that aligned with assessment findings and objectives. There is no system in place to determine when and how often an individual with a 24-hour plan requires reassessment of in vivo supports. Reassessment of the 24-hour plans should be done on an individualized basis as determined by procedures, and this should be monitored as part of the F.4 monitoring tool. There is not currently a database in place to track how often the individual should be reassessed by the Physical, Occupational, or Speech Therapist to determine the continued appropriateness of the 24-hour plan. There is not currently a system in

		place to provide oversight to 24-hour plan implementation. No individuals currently have 24-hour Rehabilitation Support Plans, as this tool and system have not been developed. **Compliance:** Partial. **Current recommendations:** 1. Ensure that for all individuals receiving direct treatment by Rehabilitation Therapists, progress towards objectives is documented in the WRP and focus, objectives, and interventions are modified as needed. 2. Develop and implement a database to track individuals with 24-hour plans, as well as when staff has received competency-based training/return demonstration, and how often the individual should be reassessed by the POST team member(s) to determine the continued appropriateness of the plan. 3. Develop and implement an audit tool to provide oversight to individuals with 24-hour plans to assess for appropriateness of program, alignment with assessment/reassessment findings, timeliness of reassessment, and whether plan was modified as needed.
F.4.d	Each State hospital, consistent with generally accepted professional standards of care, shall ensure that each individual who requires adaptive equipment is provided with equipment that meets his/her assessed needs and promotes his/her independence, and shall provide individuals with training and support to use such equipment.	**Current findings on previous recommendation:** **Recommendation 1, October 2007:** Develop and implement a plan to ensure that in vivo monitoring of adaptive equipment occurs as needed on an individualized basis by a professional with the clinical expertise to determine compliance with both implementation and continued appropriateness of supports. **Findings:** This recommendation has not been addressed.

		Recommendation 2, October 2007: Revise and implement current adaptive equipment log to track when a piece of equipment is ordered, the date of implementation, level of assistance of individual with device, whether training/monitoring is necessary, and when training/monitoring is provided if appropriate. **Findings:** This recommendation has not been addressed. A proposed database containing this information has been developed, but is pending revision and implementation. **Other findings:** The facility provided lists of individuals with adaptive equipment. Types of equipment included on these lists were wheelchairs, mobility devices (e.g., cane, walker), knee and wrist supports, orthotics, hearing aids, abdominal binders, CPAP and nebulizer, bed wedges, cervical pillows, helmets and dentures. According to the facility report by program, 99 individuals currently have adaptive equipment, but according to facility list of all programs, 73 individuals currently have adaptive equipment. It is unclear which data is correct at this time. According to a list of individuals with wheelchairs/mobility devices, 88 individuals currently have been issued this type of equipment. Upon interview and observation, it is noted that many individuals appear to have been issued a wheelchair, but it may not have been clinically indicated (e.g., many individuals were observed using the wheelchair to push around belongings). Upon facility report, a plan and screening tool to reassess wheelchairs to determine the level of assistance to the individual with wheelchair, indication, and clinical need has been developed but is pending implementation. According to facility report, five individuals currently use adaptive dining equipment.

		Compliance: Partial. **Current recommendations**: 1. Develop and implement a database to track all individuals with adaptive equipment, including when a piece of equipment is ordered compared to the date of implementation, level of assistance of individual with device, whether training was necessary, when training was provided if appropriate, and if/how often the individual should be reassessed by the POST team member(s) to determine the continued appropriateness of the equipment. 2. Develop and implement an audit tool to provide oversight to individuals with adaptive equipment to assess for appropriateness of equipment, use/repair of equipment, alignment with assessment/reassessment findings, timeliness of reassessment, and whether equipment was modified as needed. 3. Revise and implement Wheelchair Assessment draft to screen individuals to determine level of assistance with wheelchair, indication, and clinical need.

5. Nutrition Services		
	Each State hospital shall provide the individuals it serves, particularly those experiencing weight-related problems, adequate and appropriate dietary services consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. Erin Dengate, Assistant Director of Dietetics 2. Dawn Hartman, Clinical Dietitian Reviewed: 1. Meal Accuracy Report audit data from September 2007- February 2008 2. Nutrition Care Monitoring Tool audit data from September 2007-February 2008 regarding Nutrition Education Training and response to MNT (weighted mean across assessment sub-types) 3. Records for the following 61 individuals for all assessment types reviewed for Nutrition Care Assessments provided from September 2007- February 2008: AAD, AG, ALW, APL, ARM, BG, BPN, CDR, CE, COH, CTS, CV, DAP, DAW, DLD, DMB, DRS, EA, EI, EJ, EW, FA, GDC, GP, HK, JC, JCA, JCT, JFD, JLB, JRR, JRW, JSG, KBG, KLW, LSS, MER, MGM, MM, MRM, MW, NMK, PG, PP, RD, RDS, RE, REC, RJG, RJL, RKD, RS, RW, SAA, SAJ, SB, SC, TE, TSK, TSM and WJW 4. Audit data for September 2007-February 2008 regarding WRP integration of Nutrition Services recommendations 5. Records for the following four individuals from observed Nutrition PSR Mall group: DOE, JFD, RS and RS-2 6. Facilitator hour summary data for Dietitians for January- February 2008 7. A.D. #612 for Diets and Nourishments: Ordering, Service, and Monitoring (effective 12/18/07) 8. DMH Clinical Nutrition Weight Management Protocol (final draft 10/10/08) 9. Nutrition Care Process Procedure #800 (revised 9/1/07) 10. Nutrition Care Management WRP Procedure #805 (revised 9/1/07)

		11. Nutrition Care Management Nutrition Education Procedure #806 (revised 9/1/07) 12. Nutrition Care Management Referral Process Procedure #808 (revised 9/1/07) 13. DMH Nutrition Care Monitoring Instructions (revised and approved 11/07) 14. DMH Statewide Dietetics Department Policy: Dysphagia and Aspiration Management (final draft 11/29/07) 15. Diabetes Management 24-Week Lesson Plan 16. Teaching Responsible Eating and Exercise 24-Week Lesson Plan 17. Heart Health 12-Week Lesson Plan <u>Observed</u>: Diabetes Management PSR Mall Group
F.5.a	Each State hospital shall modify policies and procedures to require that the therapeutic and rehabilitation service plans of individuals who experience weight problems and/or related health concerns include adequate strategies and methodologies to address the identified problems and that such strategies and methodologies are implemented in a timely manner, monitored appropriately, and revised, as warranted, consistent with generally accepted professional standards of care.	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Track facilitator hours for Nutrition Services Mall groups. **Findings:** According to facility report, Dietitians are required to provide 1-2 hours a week at the PSR Mall, but this procedure has not yet been formalized and implemented. According to data from January-February, an average (of all Dietitian provider hours) of 0.5 hours per week per Dietician was provided. **Recommendation 2, October 2007:** Continue current practice. **Findings:** Upon review of procedures for Weight Management, Diets and Nourishment, Nutrition Care Process and Nutrition Care Management,

		it is noted that these procedures appear to meet generally accepted standards of practice. According to review of Meal Accuracy Report data, trays (regular and modified diets) audited from September 2007-February 2008 (total of 6019) were 95% accurate. Lesson plans written by Nutrition Services for Diabetes Management, Teaching Responsible Eating and Exercise and Heart Health appear to meet requirements of the PSR Mall/EP in regards to content and format. Upon observation of Diabetes Management PSR Mall group, it was noted that a lesson plan had been written and was being followed, and all individuals were engaged. According to record review of three individuals participating/enrolled Diabetes Management group, progress notes were completed for two out of two individuals (one individual had just joined the group), and completed per procedure for one of two individuals. Two out of three had documentation of focus, one out of three had documentation of objective(s), and none of the three had adequate documentation of intervention(s) in the WRP. Nutrition Education/Training is a direct service provided by Dietitians to individuals and is based on objective assessment findings. According to record review of a sample of Nutrition assessments across assessment sub-types, a weighted mean of 80% of Nutrition Care Assessments had evidence of Nutrition Training/Education if clinically indicated, and 95% of Nutrition Care Assessments had evidence of individual response to MNT (Medical Nutrition Therapy). The facility database for all assessment types per month for September 2007- February 2008 was reviewed, and a weighted mean of 89% of assessments audited from September 2007- February 2008

		had evidence of Nutrition Education/Training and 90% had evidence of individual response to MNT. **Compliance:** Partial. **Current recommendations**: 1. Ensure that Dietitians provide at least one hour of PSR Mall groups per week. 2. Continue current efforts to achieve compliance.
F.5.b	Each State hospital shall ensure that one or more treatment team members demonstrate competence in the dietary and nutritional issues affecting the individuals they serve and the development and implementation of strategies and methodologies to address such issues.	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Begin to audit for WRP inclusion of Nutrition Care Assessment recommendations/objectives with revised Nutrition Care Monitoring Tool. **Findings:** According to facility report and review of data, Dietitians initiated monitoring of inclusion of Nutrition recommendations into the WRP in October 2007, with the NCMT revised 11/07. However, the assessment and monitoring instructions currently do not include directions for writing recommendations in WRP language in the format of focus, objective, and intervention, with monitoring to ensure that recommendations are written in this format for efficient WRP inclusion. According to facility report, the instructions for the Nutrition Care Monitoring Tool have been revised to include monitoring of Nutrition recommendations in the WRP format, and monitoring of compliance will be initiated in April 2008. Facility data on WRP inclusion of Nutrition Care recommendations from October 2007-February 2008 indicated that 60% of recommendations

		were incorporated into the WRP. Record review of a sample of Nutrition Care assessments completed across assessment sub-types found that 46% of corresponding WRP documents contained Nutrition Care recommendations. **Recommendation 2, October 2007:** Continue current practice. **Findings:** The process by which the Nurse reports findings regarding Nutrition Services recommendations to the WRP continues; however, the process does not appear to be adequately implemented, as the data for WRP integration reveals less than substantial compliance. Currently, review of facility RN training data shows that only 7% of all nurses have been trained to competency regarding the reporting of Nutrition recommendations to the WRP. Dietitians developed training materials regarding the role of the RN in reporting RD findings/recommendations to the WRP and teach this portion of Nursing NEO training for new employees and existing employees hired prior to May 2007. However, according to facility report, it has been a challenge to encourage existing nursing employees to attend this portion of training. In addition, when Nutrition groups or other interventions are recommended, they are not written in the WRP format required (focus, objective, intervention). The implementation of this process may improve WRP integration and alignment for Nutrition Services recommendations (see Findings for Recommendation 1 above). **Compliance:** Partial. **Current recommendations:** 1. Implement revised Nutrition Care Assessment and NCMT tool

		instructions for writing Nutrition recommendations in WRP format (focus, objective, intervention) to ensure efficient WRP integration. 2. Continue current efforts to achieve compliance.
F.5.c	Each State hospital shall develop and implement policies and procedures to address the needs of individuals who are at risk for aspiration or dysphagia, including but not limited to, the development and implementation of assessments and interventions for mealtimes and other activities involving swallowing.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Continue current practice. **Findings:** The DMH Statewide Dietetics Department Policy: Dysphagia and Aspiration Management was revised and implemented in November 2007. This procedure addresses the Dietitian's role in the team process regarding dysphagia and aspiration prevention and management and appears to meet generally accepted standards of practice. **Compliance:** Substantial. **Current recommendations**: Continue current practice.
F.5.d	Each State hospital shall ensure that staff with responsibilities for assessments and interventions regarding aspiration and dysphagia has successfully completed competency-based training commensurate with their responsibilities.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Continue current practice. **Findings:** According to facility report, one new employee has been hired and has been trained to competency (at least 90%) regarding "Dining with Dysphagia" course content. At the time of the last review, it was noted that 100% of dietitians had received Dysphagia Training to competency.

		Compliance: Substantial. **Current recommendation**: Continue current practice.
F.5.e	Each State hospital shall develop and implement policies and procedures requiring treatment of the underlying causes for tube feeding placement, and ongoing assessment of the individuals for whom these treatment options are utilized, to determine the feasibility of returning them to oral intake status.	**Current findings on previous recommendations:** **Recommendation 1 and 2 October 2007:** • Continue current practice. • Collaborate with relevant disciplines (e.g., SLP, Nurses, Physicians) to develop and implement a plan/procedure to ensure ongoing assessment of the individuals receiving enteral nutrition, to determine the feasibility of returning them to oral intake status or justification of continued NPO status. **Findings:** The DMH Statewide Dietetics Department Policy for Tube Feeding (final draft 8/3/07) was implemented to describe the role the Dietitian in regards to enteral nutrition. Current procedure was reviewed and appears to meet accepted standards of practice. **Compliance:** Substantial. **Current recommendation**: Continue current practice.

6. Pharmacy Services		
	Each State hospital shall provide adequate and appropriate pharmacy services consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures that require:	**Methodology:** Interviewed: 1. Ronald O'Brien, PharmD, Acting Pharmacy Services Manager 2. Jean Dansereau, MD, Chief of Psychiatry Reviewed: 1. Random sample of recommendations made by pharmacists regarding new psychotropic medication orders 2. ASH Pharmacy Policy and Procedure #608, Clinical Interventions (October 16, 2007) 3. ASH self-assessment monitoring data 4. The charts of individuals CAL and CW
F.6.a	Upon the prescription of a new medication, pharmacists to conduct reviews of each individual's medication regimen and, as appropriate, make recommendations to the prescribing physician about possible drug-to-drug interactions, side effects, and need for laboratory work and testing; and	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Finalize and implement revised Policy and Procedure #608, Clinical Interventions. **Findings:** ASH has implemented this recommendation. **Recommendation 2, October 2007:** Continue to monitor all new psychotropic medication orders and changes in existing orders, and provide data related to recommendations made by the pharmacists. **Findings:** ASH has reviewed new medication orders, including changes in existing orders, and assessed compliance with this requirement (September 2007 to February 2008). The following is a summary outline of the

<table>
<tr>
<td></td>
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<td>mean number of recommendations made by the Pharmacy Department and their type:

<table>
<tr><td colspan="2">Total number of recommendations</td><td>251</td></tr>
<tr><td>a.</td><td>Drug-drug interactions</td><td>48</td></tr>
<tr><td>b.</td><td>Side effects</td><td>40</td></tr>
<tr><td>c.</td><td>Need for laboratory testing</td><td>7</td></tr>
<tr><td>d.</td><td>Dose adjustment</td><td>156</td></tr>
</table>

The facility's data did not include any data regarding food-drug interactions and/or drug allergies.

Compliance:
Partial.

Current recommendations:
1. Continue to monitor this requirement.
2. Provide data analysis to provide comparisons with the previous review period and to identify and address any patterns in the areas of concern by the pharmacists'.
3. Ensure that pharmacists' recommendations address all areas of concern, including, but not be limited to, food-drug interactions and drug allergies.
4. Ensure that current vacancies in pharmacy staff are filled.</td>
</tr>
<tr>
<td>F.6.b</td>
<td>Physicians to consider pharmacists' recommendations, and for any recommendations not followed, document in the individual's medical record an adequate clinical justification.</td>
<td>Current findings on previous recommendations:

Recommendations 1 and 2, October 2007:
• Monitor all instances of pharmacist's recommendations that were not accepted by the physicians and documentation by the prescribing physician of the rationale.
• Analyze data and address factors related to recommendations not accepted by physicians.</td>
</tr>
</table>

		Findings: ASH reported that all of the recommendations made by the Pharmacists during this review period have been accepted by the physicians. The facility indicated that a form was developed to track situations when recommendations are not accepted and/or addressed by the prescribing physicians. **Other findings:** This monitor reviewed the charts of two individuals (CAL and CW) to assess the type of recommendation(s) made by the pharmacist and physician's follow-up. In the first case (CW), the recommendation was to institute vital signs checks upon restarting clozapine treatment. The pharmacist recommended precautions regarding drug-drug interactions involving beta and alpha blocker medications in the case of CAL. In both cases, the review showed that the recommendations were followed in a timely manner. **Compliance:** Substantial. **Current recommendations**: Continue to monitor this requirement.

7. General Medical Services		
		Methodology: Interviewed: 1. Douglas Shelton, MD, Chief Physician and Surgeon 2. Hussein Akhavan, MD, Physician and Surgeon 3. Thomas Cahill, MD, Physician and Surgeon 4. Willard Towle, MD, Physician and Surgeon 5. Ali Akhavan, MD, Physician and Surgeon 6. Susan Smith, MD, Physician and Surgeon 7. Ronald Staib, MD, Physician and Surgeon 8. Hani Boutros, MD, Physician and Surgeon 9. Cynthia Davis, RN, Nurse Administrator Reviewed: 1. The charts of the following 11 individuals who were transferred to an outside medical facility or the infirmary (at unit 1) during this review period: ALW, BBA, CTS, CW, DM, GKR, JB, LEB, MDK, RD and RV 2. DMH Medical Surgical Progress Notes Audit Form 3. DMH Medical Surgical Progress Notes Audit Form Instructions 4. DMH Integration of Medical Conditions into the WRP Audit Form 5. DMH Integration of Medical Conditions into the WRP Audit Form Instructions 6. DMH Medical Transfer Audit Form 7. DMH Medical Transfer Audit Form Instructions 8. DMH Diabetes Mellitus Audit Form 9. DMH Diabetes Mellitus Audit Form Instructions 10. DMH Hypertension Audit Form 11. DMH Hypertension Audit Form Instructions 12. DMH Dyslipidemia Audit Form 13. DMH Dyslipidemia Audit Form Instructions 14. DMH Asthma/COPD Audit Form

		15. DMH Asthma/COPD Audit Form Instructions 16. ASH Ongoing Medical Care Monitoring Form 17. ASH Ongoing Medical Care Monitoring summary data (May to July 2007) 18. ASH data regarding timeliness of consultations/laboratory testing (September 2007 to February 2008) 19. ASH data regarding availability of outside hospital records upon individual's return from hospitalization (September 2007 to February 2008) 20. ASH Diabetes Care Monitoring Form 21. ASH Diabetes Care Monitoring summary data (January and February 2008) 22. ASH Asthma/COPD Care Monitoring Form 23. ASH Asthma/COPD Monitoring summary data (December 2007 to January 2008) 24. ASH Hepatitis C Care Monitoring Form 25. ASH Hepatitis C Care Monitoring summary data (October and December 2007 and January 2008) <u>Observed</u>: 1. Toured Urgent Care Room 2. Toured Unit 1 (Infirmary)
F.7.a	Each State hospital shall provide adequate, appropriate, and timely preventive, routine, specialized, and emergency medical care to all individuals in need of such services, consistent with generally accepted professional standards of care. Each State hospital shall ensure that individuals with medical problems are promptly identified, assessed, diagnosed, treated, monitored and, as monitoring indicates is necessary, reassessed, diagnosed, and treated, consistent with generally	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Revise the Medical Policies and Procedures to address and correct the deficiencies outlined by this monitor under Recommendation #1 above. It is suggested that the facility organize the required information within the following three main documents: a. Medical Attention to Individuals Policy and Procedure: This document should provide requirements for: 1) initial medical assessment of individuals upon admission and for regular

	accepted professional standards of care.	reassessments during the hospital stay; 2) assessing changes in the physical status by nursing and medical staff, including physician-nurse communications; 3) transfer and return transfer of individuals for/from care at a general medical facility; 4) integration of medical and mental health care; and 5) monitoring the timeliness and quality of these services. b. Medical Emergency Response Policy and Procedure: This document should provide requirements regarding: 1) the organization, training, equipment and operations of a medical emergency response system for the immediate assessment and initial care of individuals pending transfer to a general medical facility; 2) medical emergency drills procedure, including frequency of drills, composition of the teams, adequate scenarios of simulated emergencies, drill evaluation sheets and a performance improvement system; and 3) monitoring the timeliness and quality of these services. c. Medical Diagnostic Testing and Consultations: This document should provide requirements for 1) obtaining medical diagnostic testing and consultation services; 2) providing appropriate follow-up regarding these services; and 3) monitoring the timeliness and quality of these services. **Findings:** ASH has yet to implement this recommendation. The facility has reportedly developed draft revisions of its Medical Policies and Procedures to address the recommendation. The facility provided an outline of the planned revisions, but did not provide supporting documents. The planned revisions are aligned with the recommendation. **Recommendation 2, October 2007:** Implement the revised policies and procedures.

		Findings: Same as above. **Recommendation 3, October 2007:** Monitor this requirement based on at least a 20% sample. **Findings:** The DMH recently standardized monitoring instruments, indicators and operational instructions for this section of the EP. The following is an outline of these instruments: 1. DMH Medical Surgical Progress Notes Audit Form 2. DMH Integration of Medical Conditions into the WRP Audit Form 3. DMH Medical Transfer Audit Form 4. DMH Diabetes Mellitus Audit Form 5. DMH Hypertension Audit Form 6. DMH Dyslipidemia Audit Form 7. DMH Asthma/COPD Audit Form The implementation of these tools should facilitate more meaningful, streamlined and standardized data. The DMH has yet to standardize the monitoring forms regarding the initial admission medical assessment and the emergency medical response system. This monitor has asked the facilities to report internal monitoring data under sections F.7.b.i (initial admission assessment and medical surgical progress notes), F.7.b.ii (medical emergency response, medical transfers and integration of medical conditions into the WRPs) and F.7.c (specific medical conditions: diabetes mellitus, hypertension, dyslipidemia and Asthma/COPD) as appropriate to the requirements in these sections.

Recommendation 4, October 2007:
Address and correct factors related to low compliance and deficiencies outlined by this monitor under Other Findings above.

Findings:
ASH has established a Medical Services EP Performance Improvement Team. The facility plans to utilize this process to address low compliance and the deficiencies found by the CM. The process includes communications with the Department of Medicine for systemic performance issues and with the Chief Physician and Surgeon for specific practitioner issues.

Other findings:
This monitor reviewed the charts of 11 individuals who were transferred to an outside medical facility or the Infirmary (at unit 1) during this review period. The following table outlines the individuals' initials, date/time of physician evaluation at the time of transfer and the reason for the transfer:

Individual	Date and time of MD evaluation	Reason for transfer
ALW	02/13/08 03:35	R/O myocardial infarction
BBA	12/21/08 21:00	Abdominal pain
CTS	09/30/07 08:00	Pneumonia
CW	02/02/08 07:15	R/O bowel obstruction
DM	11/16/08 10:07	New onset seizure activity
GKR	02/07/08 12:15	Recurrent seizure activity
JB	10/22/07 17:10	Pneumonia
LEB	10/29/07 15:50	Increase in confusion
LEB	11/01/08 19:30	S/P fall, acute mental status change
MDK	12/13/07 07:45	Chest pain
RD	1/14/08 09:20	S/P severe head injury

RV	01/09/08 21:50	Fever, urinary tract infection and hypotension		

The review found evidence of timely and appropriate care in most charts. However, a persisting pattern of deficiencies was found as follows:

1. There was evidence of a delay in the medical reevaluation and transfer of an individual who suffered from progressive abdominal pain with fever. The nursing evaluation and physician-nurse communications in this situation were delayed and inadequate.
2. The medical evaluation of an individual who had suffered severe head trauma with sub-conjunctival bleeding and possible nasal fracture did not include neurological examination of the motor and sensory functions (prior to the transfer to an outside facility).
3. The nursing documented assessment of an individual who was found on the floor following a presumed fall and was incontinent of urine did not address the possibility of seizure activity. This individual subsequently developed new onset of word finding difficulty, but the medical evaluation did not include appropriate differential diagnosis.
4. The medical evaluation of an individual who suffered possible bowel obstruction did not address the rationale for continued treatment with high-risk medication without documented justification.
5. The nursing documentation of the change in the medical status did not specify the name of the physician who was notified of the change in most cases reviewed.
6. There was evidence of incomplete neurological and medical work up of an individual who developed recurrent seizure activity.
7. There was no consistent system of documentation in the charts reviewed of the time of transfer of individuals to an outside facility.
8. There was no consistent system of documentation of the physician's

		evaluation upon transfer to the general facility (Progress Notes or Urgent Care Room Record). 9. There was discrepant documentation of the time of medical evaluation between nursing and medical notes. **Compliance:** Partial. **Current recommendations:** 1. Finalize revisions of the Medical Policies and Procedures and submit an outline of these revisions aligned with the ten areas of deficiencies reported previously by this monitor, with supporting documents. 2. Implement the revised medical Policies and Procedures and report the effective data of implementation for each specific Policy/Procedure. 3. Ensure proper oversight of medical services to correct this monitor's clinical findings of deficiencies (listed in Other Findings above).
F.7.b	Each State hospital shall develop and implement protocols and procedures, consistent with generally accepted professional standards of care, that:	Please see sub-cells for compliance findings.
F.7.b.i	require the timely provision of initial and ongoing assessments relating to medical care, including but not limited to, vision care, dental care, and laboratory and consultation services;	**Current findings on previous recommendations:** **Recommendations 1 and 2, October 2007:** • Continue to monitor this requirement based on at least a 20% sample, and analyze and correct factors related to low compliance. • Ensure that monitoring indicators address the completeness and quality of the assessments.

Findings:
As mentioned earlier, the DMH has finalized a standardized instrument for monitoring the Medical Surgical Progress Notes. The tool addresses the completeness and quality of the reassessments. The DMH has yet to finalize a standardized instrument regarding the Admission Medical Assessments.

ASH used its current tools to monitor the Admission Medical Assessments. The data were presented in D.1.c.i. The facility also used its Ongoing Medical Care Monitoring Form (October to December 2007) and reviewed an average sample of 88% of the annual physical reassessments performed each month. The following is an outline of the indicators and corresponding mean compliance rates:

1.	*Annual history and physical completed on anniversary month*	83%
2.	*All medical conditions identified*	93%
3.	*An appropriate medical work up has been done for each condition*	95%
4.	*Appropriate consultations (done), with timely completion*	87%
5.	*Has there been a change in interventions in response to changes in medial needs?*	99%
6.	*Has the physician reviewed and followed up on the test results and the recommendations of the consultants?*	60%
7.	*Has the individual received appropriate vision care within acceptable time-frames?*	74%
8.	*Have all Focus 6 conditions (except health care maintenance) been addressed with WRP objectives and interventions?*	60%
9.	*Have services/treatment as outlined in the WRP been consistently provided for all the*	89%

	needs/conditions addressed?	
10.	*Was any progress, lack of progress, or need for changes in services noted in the Present Status section of the Case Formulation (WRP)?*	20%
11.	*Has there been a change in interventions in response to changes in medical needs?*	99%

In general, the facility's data regarding the annual reassessments of individuals showed improved compliance compared to the data presented for the last review period.

ASH presented incomplete data using the DMH Medical-Surgical Progress Note Audit Form.

Other findings:
See D.1.c.

Compliance:
Partial.

Current recommendations:
1. Standardize the monitoring tool regarding the initial admission assessments for use across facilities.
2. Monitor this requirement based on 100% sample using the DMH Admission (Initial) Medical Assessment Audit Form (when completed) and the DMH Surgical Medical Progress Notes Audit Form.
3. Provide data analysis that evaluates low compliance and delineates relative improvement (during the reporting period and compared to the last period).
4. Implement corrective actions to address the lack of documentation of follow-up when individuals refuse the examination or parts of the examination.

<table>
<tr>
<td>F.7.b.ii</td>
<td>require the timely provision of medical care, including but not limited to, vision care, dental care, and laboratory and consultation services; timely and appropriate communication between nursing staff and physicians regarding changes in an individual's physical status; and the integration of each individual's mental health and medical care;</td>
<td>
Current findings on previous recommendation:

Recommendation, October 2007:
Continue to monitor this requirement based on at least a 20% sample, and analyze and correct factors related to low compliance.

Findings:
As mentioned earlier, DMH developed standardized tools to monitor Medical Transfers and the Integration of Medical Conditions into the WRP. ASH has yet to implement these tools. DMH has yet to develop standardized tool to address the Medical Emergency Response System.

The facility presented data regarding the timeliness of consultations/laboratory testing, including on-site and off-site medical and specialty care (September 2007 to February 2008). These data were based on an average sample of 100%. The following is a summary of the area reviewed and corresponding mean compliance rates:

<table>
<tr><td>1.</td><td>On-site Foot Clinic: within four weeks</td><td>87%</td></tr>
<tr><td>2.</td><td>On-site Public Health clinic: within two weeks</td><td>60%</td></tr>
<tr><td>3.</td><td>On-site Podiatry clinic: within six weeks</td><td>99%</td></tr>
<tr><td>4.</td><td>On-site Ophthalmology clinic: within four weeks</td><td>94%</td></tr>
<tr><td>5.</td><td>On-site Optometry clinic: within six weeks</td><td>60%</td></tr>
<tr><td>6.</td><td>Outside medical care: within eight weeks</td><td>90%</td></tr>
<tr><td>7.</td><td>In-house Stat lab reported within 90 minutes of order</td><td>96%</td></tr>
</table>
In general, the data are comparable to those presented for the last review period.

Compliance:
Partial.
</td>
</tr>
</table>

		Current recommendations: 1. Standardize the monitoring tools regarding the Medical Emergency Response System and Drills for use across state facilities. 2. Monitor this requirement using the DMH standardized tools regarding Medical Emergency Response System (when completed), Medical Transfers and Integration of Medical Conditions into the WRP Audit Forms.
F.7.b.iii	define the duties and responsibilities of primary care (non-psychiatric) physicians;	**Current findings on previous recommendation:** **Recommendation, October 2007:** Ensure that the Duty Statement outlines the performance standards and expectations as above. The Duty Statement may refer to the revised policies and procedures. **Findings:** Implementation of this recommendation is contingent on completion and finalization of revisions to the Medical Care Policies and Procedures. **Compliance:** Partial. **Current recommendations**: Ensure that the Duty Statement outlines the performance standards and expectations as above. The Duty Statement may refer to the revised policies and procedures.
F.7.b.iv	ensure a system of after-hours coverage by primary care physicians with formal psychiatric training (i.e., privileging and proctorship) and psychiatric backup support after hours; and	**Current findings on previous recommendation:** **Recommendation, October 2007:** Continue current practice.

		Findings: ASH has continued its practice using Psychiatric and Medical Officers-of-the-Day. **Compliance:** Substantial. **Current recommendations**: Continue current practice.
F.7.b.v	endeavor to obtain, on a consistent and timely basis, an individual's medical records after the individual is treated in another medical facility.	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Continue to monitor all hospitalizations. **Findings:** The facility has data based on a 100% sample (September 2007 to February 2008). The mean compliance rate was 72%, reflecting some decrease in compliance compared to the previous review period. The facility did not provide data analysis. **Recommendation 2, October 2007:** Ensure that upon the individual's return to ASH, there is physician documentation that summarizes the outcome of hospitalization and implications for future care. **Findings:** The DMH standardized tool regarding medical transfers addresses this recommendation. ASH has yet to implement this tool (see F.7.b.ii). **Compliance:** Partial.

<table>
<tr><td></td><td></td><td>Current recommendations:
1. Monitor this requirement based on a 100% sample.
2. Provide data analysis that evaluates low compliance and delineates relative improvement (during the reporting period and compared to the last period).</td></tr>
<tr><td>F.7.c</td><td>Each State hospital shall ensure that physicians monitor each individual's health status indicators in accordance with generally accepted professional standards of care, and, whenever appropriate, modify their therapeutic and rehabilitation service plans to address any problematic changes in health status indicators.</td><td>Current findings on previous recommendations:

Recommendation 1, October 2007:
Continue current monitoring and ensure at least a 20% sample and analyze and correct factors related to low compliance.

Findings:
AS mentioned earlier, the DMH has developed standardized tools to monitor the care of the following medical conditions: Diabetes Mellitus, Hypertension, Dyslipidemia and Asthma/COPD. ASH has yet to implement this tool. The facility presented data based its current tools for monitoring of Diabetes Mellitus (January and February 2008), Asthma/COPD (December 2007 to February 2008) and Hepatitis C (October and December 2007 and January 2008). The average samples were 13%, 13% and 18% of individuals diagnosed with these conditions, respectively. ASH did not present monitoring data regarding care of hypertension during this review period. The following is a summary outline of the indicators and corresponding mean compliance rates:

Diabetes Mellitus:

<table>
<tr><td>1.</td><td>The individual has been evaluated and supporting documentation is completed at least quarterly</td><td>54%</td></tr>
<tr><td>2.</td><td>HgbA1C was ordered quarterly</td><td>73%</td></tr>
<tr><td>3.</td><td>The HgbA1C is equal to or less than 7%</td><td>74%</td></tr>
<tr><td>4.</td><td>Blood sugar is monitored regularly</td><td>88%</td></tr>
<tr><td>5.</td><td>Urinary micro albumin monitored annually</td><td>41%</td></tr>
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</table>

		6.	*If the urine micro albumin is greater than 30. ACE or ARP is prescribed, if not otherwise contraindicated*	45%
		7.	*The lipid profile is monitored on admission or at the time of diagnosis and at least annually*	93%
		8.	*LDL is less than 100mg/dl or there is a plan of care in place to appropriately treat the LDL*	61%
		9.	*Blood pressure is monitored weekly*	91%
		10.	*If blood pressure is greater than 130/80, there is a plan of care in place to appropriately lower the blood pressure*	13%
		11.	*An eye exam by an ophthalmologist/optometrist was completed at least annually*	79%
		12.	*Podiatry care was provided by a podiatrist at least annually*	88%
		13.	*A dietary consultation was considered and the recommendation was followed, as applicable*	94%
		14.	*Diabetes is addressed in Focus 6 of the WRP*	97%
		15.	*Focus 6 for Diabetes has appropriate objectives and interventions for this condition*	94%
		Asthma/COPD:		
		1.	*The individual has been evaluated and supporting documentation completed at least quarterly*	37%
		2.	*For individual's with a diagnosis of COPD, a baseline chest x-ray has been completed*	100%
		3.	*If a rescue inhaler is being used more than 2 days a week, the individual has been assessed and an appropriate plan of care has been developed*	45%
		4.	*If the individual is currently a smoker, a smoking cessation program has been discussed and included in the WRP*	19%

		5.	*Asthma or COPD is addressed in Focus 6 of the WRP*	81%
		6.	*Focus 6 for Asthma/COPD has appropriate objectives and interventions*	49%
		7.	*The individual has been assessed for a flu vaccination*	70%
		8.	*If the individual has a diagnosis of COPD, a Pneumococcal vaccine has been offered, unless contraindicated*	49%

Hepatitis C:

1.	*Has the individual been tested for HIV or encouraged to be tested?*	100%
2.	*Has the individual been tested for Hepatitis A?*	93%
3.	*Is the individual with advanced liver disease screened for hepatocellular carcinoma? (Imaging and/or AFP).*	99%
4.	*Is the individual who is not being treated but has detectible virus evaluated in clinic at least every 6 months for signs and symptoms of liver disease?*	99%
5.	*If an individual is not being treated but has detectible virus, is a CBC and ALT level completed at least every 6 months?*	99%
6.	*If the individual is being treated for Hepatitis C, has he had a pre-treatment psychiatric evaluation?*	100%
7.	*If the individual is being treated for Hepatitis C, has he had all recommended pre-treatment tests?*	100%
8.	*Is the individual under treatment receiving the recommended tests at appropriate intervals?*	NA
9.	*Is there documentation that an individual receiving interferon/ribavirin is receiving psychiatric monitoring?*	NA

ASH reported that increased compliance is expected when the new

		requirement for implementation of quarterly reassessments is implemented (April 2008) and the physician staffing is augmented (July and August 2008). The facility reviewed its data and provided the following analysis/explanation regarding items with low compliance: Diabetes Mellitus: Micro albumin yearly testing (#5), recommendation for use of ACE inhibitor routinely (#6) and Lowering of BP to levels below 130/80 (#10) were newly implemented as guidelines at ASH and compliance is expected to increase over the next six months. Asthma/COPD: 1. Monitoring of rescue inhaler use (#3) was a new procedure and improved compliance is expected over the next six months. 2. The facility reports that a Smoking Cessation program (#4) is available at ASH by request of the WRPTs to the PSR Mall. Additional training of the medical staff and WRPTs on this request process is planned for the next six months, with improved compliance expected over the next 12 months. 3. Monitoring of the integration of medical conditions into the WRP (#6) will begin in March and is expected to improve compliance. 4. Physician notification using the tracking of COPD Axis III diagnosis (#8) is expected to improve compliance. **Recommendation 2, October 2007:** Develop and implement formalized mechanisms to improve integration of medical staff into the interdisciplinary functions of the WRP. **Findings:** ASH reported that authorization was received to hire four to eight more Physician and Surgeons. The facility anticipates that this, along

		with the streamlining of the Medical Sick Call process, will allow physicians to complete quarterly reassessments of the medical condition and attend some of the WRPCs of individuals with complex medical conditions. As mentioned earlier, the new DMH tool "Integration of Medical Condition into WRP Audit Form" will be utilized to monitor this function. **Compliance:** Partial. **Current recommendations**: 1. Monitor this requirement using the DMH standardized tools regarding specific medical conditions (diabetes mellitus, dyslipidemia, hypertension and asthma/COPD) in addition to any other instruments that address this requirement (e.g. hepatitis C). 2. Provide data analysis that evaluates low compliance and delineates relative improvement (during the reporting period and compared to the last period).
F.7.d	Each State Hospital shall monitor, on a continuous basis, outcome indicators to identify trends and patterns in the individual's health status, assess the performance of medical systems, and provide corrective follow-up measures to improve outcomes.	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Develop and implement a formalized physician peer review system that utilizes indicators aligned with the standards and expectations outlined in F.7.a. **Findings:** ASH has yet to implement this recommendation. The revised Medical Care Policies and Procedures are expected to outline the formalized peer review system. **Recommendation 2, October 2007:** Continue monitoring of physicians' adherence to practice guidelines and

		expand these guidelines to address areas outlined in the trigger/key indicators for medical care. **Findings:** Same as in F.7.c (regarding adherence to the facility's guidelines in the care of Diabetes Mellitus, Asthma/COPD and Hepatitis C). The facility has yet to develop any additional indicators to those outlines in the key indicators. **Recommendation 3, October 2007:** Ensure monitoring of emergency medical care and response system. **Findings:** ASH has yet to implement this recommendation. The facility plans to begin semiannual emergency drills and monitoring of emergency medical care within the next review period. This recommendation will be covered in F.7.b.ii. **Recommendation 4, October 2007:** Ensure collaboration between medical services, standards compliance and information technology to provide data on all the medical triggers/key indicators. The facility may establish additional indicators of outcomes to the individuals and the medical systems of care. **Findings:** The facility reported that the Chief Physician and Surgeon currently collaborates with Standards Compliance in reviewing all medical triggers/key indicators data on a monthly basis. The facility plans to utilize the newly established Medical Services EP Performance Improvement Team, the Medical Executive Committee and the Department of Medicine in review and analysis as well as providing recommendations for corrective actions.

		Recommendation 5, October 2007: Identify trends and patterns based on clinical and process outcomes. **Findings:** ASH has yet to implement this recommendation. The facility's self-monitoring data represent a step in the right direction. **Compliance:** Partial. **Current recommendations:** 1. Utilize the Medical Services EP Performance Improvement Team in the review and analysis of all the medical triggers/key indicators, establishment of any additional indicators of outcomes to the individuals and the medical systems of care and development and implementation of corrective actions. 2. Develop and implement a formalized physician peer review system that utilizes indicators aligned with the standards and expectations outlined in F.7.a. 3. Identify trends and patterns based on clinical and process outcomes.

8. Infection Control		
	Each State hospital shall develop and implement infection control policies and procedures to prevent the spread of infections or communicable diseases, consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. Gina M. Dusi, PHN II 2. Brandi Norico, PHN I Reviewed: 1. ASH's progress report and data 2. Infection Control Committee minutes for 11/29/07, 12/27/07, 1/24/08, and 2/28/08 3. Infection Control Performance Improvement/Risk Assessment reports 4. Summary reports of audit findings and corrective actions submitted to the Infection Control Committee for December 2007-March 2008 5. Department of Medicine Meeting minutes for March 20, 2008 6. Infection Control Inter-Rater Reliability data 7. Surveillance data for October 2007 for viral illness 8. Follow-up instructions for auditing issues 9. Infection Control's automated database 10. Proposed revisions for statewide monitoring tools 11. Medical records for the following 43 individuals: AG, AW, BR, CMC, DB, DB, DD, DL, DSC, DVE, DWW, EJ, EMW, ES, FJG, FVR, GAW, JC, JCA, JF, JFD, JG, JJG, JJM, JMO, JNL, JP, JSP, LLD, LRS, LWH, MM, MO, NMK, RD, RJL, RM, TAQ, TWS, VJA, WH, WS and YVY
F.8.a	Each State hospital shall establish an effective infection control program that:	**Compliance:** Partial.
F.8.a.i	actively collects data regarding infections and communicable diseases;	**Current findings on previous recommendations:**

		Recommendation 1, October 2007: Implement revised monitoring instruments. **Findings:** ASH implemented the statewide Infection Control monitoring instruments and instructions in October 2007. However, since the instruments were based on PSH's Infection Control system, some of the indicators from the tools are not aligned with ASH's policies and procedures, which has resulted in some areas demonstrating poor compliance. This issue has been noted previously at the other facilities. These areas of discrepancies between the monitoring instruments and ASH's practices are noted in the associated sections. The statewide Infection Control committee has discussed these issues and appropriate changes to the instruments are currently being reviewed to accurately reflect Infection Control practices at all facilities. At the time of this review, the staff of the Infection Control Department was conducting the auditing. According to ASH's progress report, instruments that had inter-rater reliability under 85% included the following: • MRSA: 82% • HIV: 69% • Immunizations refused: 75% The auditors reviewed the discrepancies and agreed on an interpretation. Further inter-rater reliability testing will be conducted on the existing and the new instruments to reach acceptable levels (85% or above). The Infection Control Department data reflect chart reviews for individuals that meet the review criteria only in Program IV. As noted

		in the last report, as the facility progresses in the process, it is expected that all units will be audited regarding Infection Control and the requirements of the EP. **Recommendation 2, October 2007:** Continue to monitor this requirement. **Findings:** <u>PPD</u> ASH's data from the Admission PPD Monitoring Form audit (October 2007-February 2008) based on a 20% mean sample of PPDs due each month (N) indicated 100% compliance with the requirement that there was notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings. ASH's data from the Annual PPD Monitoring Form audit (October 2007-February 2008) based on a 20% mean sample of annual PPDs due each month (N) indicated 100% compliance with the requirement that there was notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings. ASH's data from the Positive PPD Monitoring Form audit (October 2007-February 2008) based on a 33% mean sample of positive PPDs each month (N) indicated 100% compliance with the requirement that there was notification by the unit via a PPD form sent to the Infection Control Department for all PPD readings. <u>MRSA</u> ASH's data from the MRSA Auditing Form audit (October 2007-February 2008) based on a 100% sample of individuals with MRSA each month (N) indicated 100% compliance with the requirement that the lab notify the Infection Control Department when an individual has a

		positive culture for MRSA, and 100% mean compliance with the requirement that the lab notify the unit housing the individual that a positive culture for MRSA has been obtained. <u>Hepatitis C</u> ASH's data from the Hepatitis C Monitoring Form audit (October 2007-February 2008) based on a 71% mean sample of individuals Hepatitis C+ each month (N) indicated 100% mean compliance with the requirement that notification by the lab was made to the Infection Control Department identifying the individual with a positive Hepatitis C Antibody and 99% mean compliance with the requirement that the lab notify the unit housing the individual that he/she has had a positive Hepatitis C Antibody test. <u>HIV</u> ASH's data from the HIV Positive Monitoring Form audit (October 2007-February 2008 October 2007-February 2008) based on a 100% sample (8) of individuals HIV+ each month (N) indicated 100% mean compliance with the requirement that notification by the lab was made to the Infection Control Department identifying the individual with a positive HIV Antibody and 100% mean compliance with the requirement that notification was made to the unit housing the individual that he/she has a positive HIV Antibody test. The auditors noted that individuals admitted with a known pre-existing diagnosis of HIV do not receive HIV antibody testing but do receive other laboratory work such as a CD4 count used to assess immune status and susceptibility to opportunistic infections. <u>Sexually Transmitted Disease</u> ASH's data from the Sexually Transmitted Disease Auditing Form indicated that there were no cases of newly identified STDs during this reporting period.

		Immunizations ASH's data from the Immunization Monitoring Form audit (October 2007-February 2008) based on a 20% mean sample of immunizations done each month (N) indicated 99% mean compliance with the requirement that there was notification by the lab to the Infection Control Department of an individual's immunity status and 94% mean compliance with the requirement that there was notification by the lab to the unit housing the individual regarding their immunity status. Refusals ASH's data from the Refusal Admission/Annual Lab Work or Diagnostic Test Auditing Form (October 2007-February 2008) based on a 57% mean sample of refused admission/annual lab work or PPD each month (N) indicated 100% compliance with the requirement that notification by the unit that the individual refused his/her admission or annual lab work or admission or annual PPD was sent to the Infection Control Department. ASH's data from the Immunization Refusals Monitoring Form audit (October 2007-February 2008) based on a 25% mean sample of individuals who refused their immunizations each month (N) indicated 100% compliance with the requirement that notification by the unit was made to the Infection Control Department of the individual's refusal of the immunization(s) and 9% compliance with the requirement that the unit notified the Infection Control Department when the individual consented and received the immunization(s). In an interview, the Infection Control staff noted that because ASH has a clinic in which individuals are seen regarding immunizations and other infectious issues, they are not dependent on unit staff to notify them of refusals since this information comes from the clinic appointments. Thus, some indicators that reflected notification by the unit staff to the Infection Control Department were interpreted by

		the auditors as notification that included the clinic, which was scored as compliance. **Other findings:** In addition to the above data, ASH provided data regarding outbreak cluster cases for 14 individuals with gastrointestinal viral illness on unit 1 during October 2007. **Current recommendations:** 1. Reconcile inconsistencies between current Infection Control policies/procedures and indicators for monitoring. 2. Continue to conduct inter-rater reliability testing until values of 85% or above are achieved. 3. Continue to monitor this requirement.
F.8.a.ii	assesses these data for trends;	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Provide data in a format that demonstrates compliance with this requirement. **Findings:** The table data provided by ASH regarding this requirement could not be accurately interpreted. It was discussed during the review that either narrative data discussing data trends and/or graphs and meeting minutes identifying data trends would provide more meaningful information and would demonstrate compliance with the EP. **Recommendation 2, October 2007:** Continue to monitor this requirement. **Findings:** This monitor's review of the Infection Control Committee minutes for

		11/29/07, 12/27/07, 1/24/08 and 2/28/08 found comprehensive discussions of the facility's trends for hospital-associated infections that included respiratory tract infections, skin infections, urinary tract infections and gastroenteritis. In addition, TB, Hepatitis A and B, Hepatitis C, HIV, sexually transmitted diseases (STDs) and MRSA trends were addressed in the minutes. Issues identified such as immunization records for readmitted individuals, borderline results on Hepatitis A testing, Pertussis, and Influenza included a discussion of the issue with recommendations and actions. Also, the minutes indicated that there had been outbreak clusters of gastroenteritis on unit 1 in October 2007 and on unit 14 in January 2008. Both units were quarantined, which prevented the spread to other units. In addition, there was an extensive description regarding the results of a Legionella antibody titer, which included consultation with the California Department of Public Health and the San Luis Obispo County Public Health Department. While the individual was being retested, ASH's Outbreak Management Team and Public Health Department reviewed the Centers for Disease Control and Prevention recommendations for this situation and implemented an inspection of the plumbing system by an Environmental Specialist. All residents residing on the unit (44) were moved off the unit and their charts were reviewed, with the conclusion that none had symptoms associated with health care-associated Legionnaire's disease. The case was determined not to be Legionellosis. However, it was decided that for every case of suspected or documented pneumonia, a sputum culture testing for Legionella species will be obtained for six months and the data reviewed for further follow-up. Also, included in all Infection Control Meeting minutes was information regarding employee illnesses including gastroenteritis, TSTs, respiratory fit tests, peak flow tests and substance exposures. Review of ASH's Infection Control Committee minutes indicated that the department is beginning to integrate its audit findings into the minutes.

		Overall, the minutes from the Infection Control Committee and the Infection Control Performance Improvement/Risk Assessment reports were comprehensive and adequately validated that ASH assesses its data for trends, analyzes, develops corrective plans of action, monitors, and thoroughly documents clinical outcomes. **Current recommendations**: 1. Provide data in a format that demonstrates compliance with this requirement. 2. Continue to monitor this requirement.
F.8.a.iii	initiates inquiries regarding problematic trends;	**Current findings on previous recommendation:** **Recommendation, October 2007:** Same as F.8.a.ii. **Findings:** The table data provided by ASH regarding this requirement could not be interpreted. As previously noted, either narrative data discussing data trends and/or graphs, reports and meeting minutes identifying problematic data trends would provide more meaningful information and would demonstrate compliance with the EP. The minutes from the Infection Control meetings and the Infection Control Performance Improvement/Risk Assessment reports indicated that inquiries were initiated for problematic issues regarding immunization records for readmissions, borderline results for Hepatitis A testing, timeliness of Infection Reporting Worksheets, Focus 6 problems related to infectious diseases not being opened, placement of laboratory results in charts, lack of treatment information from transferring facilities and outbreak cluster cases.

		Current recommendations: See F.8.a.ii.
F.8.a.iv	identifies necessary corrective action;	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Same as F.8.a.ii. **Findings:** Also see F.8.a.ii and F.8.a iii <u>PPD</u> ASH's data from the Admission PPD Monitoring Form audit (October 2007-February 2008) based on a 20% mean sample of PPDs due each month (N) indicated 100% compliance with the requirement that PPDs were ordered by the physician during the admission procedure and 100% compliance with the requirement that a chest x-ray was ordered by the physician if indicated. ASH's data from the Annual PPD Monitoring Form audit (October 2007-February 2008) based on a 20% mean sample of annual physical examination due with PPD by month (N) indicated 100% compliance with the requirement that PPDs were ordered by the physician during the annual review procedure. ASH's data from the Positive PPD Monitoring Form audit (October 2007-February 2008) based on a 33% mean sample of individuals PPD+ each month (N) indicated 100% mean compliance with the requirement that all positive PPDs receive PA and Lateral chest x-rays and 60% mean compliance with the requirement that all positive PPDs receive an evaluation by the Med-Surg Physician. This item represents a discrepancy between the monitoring instrument and ASH's policy

		regarding individuals with a known prior history of evaluation and treatment for a positive PPD. The facility reported there were no individuals with active disease identified during this review period. <u>Immunizations</u> ASH's data from the Immunization Monitoring Form audit (October 2007-February 2008) based on a 20% mean sample of immunizations each month (N) indicated 1% mean compliance with the requirement that immunizations were ordered by the physician within five days of receiving notification by the lab. ASH's current process for immunizations includes referral to the medical clinic for an appointment which is not within the timeframes required by the monitoring tool. <u>STDs</u> ASH's data from the Sexually Transmitted Disease Auditing Form Immunization Monitoring Form audit (October 2007-February 2008) indicated that there were no cases of STDs during this review period. <u>Hepatitis C</u> ASH's data from the Hepatitis C Monitoring Form audit (October 2007-February 2008) based on a 71% mean sample of individuals Hepatitis C+ each month (N) indicated 0% compliance with the requirement that the Hepatitis C Tracking sheet was initiated for each individual testing positive for Hepatitis C Antibody and 99% mean compliance with the requirement that the individual's Medication Plan was evaluated and immunizations for Hepatitis A and B were considered. ASH's procedures do not include the use of a tracking sheet for positive Hepatitis C Antibodies, which accounts for the 0% compliance. The discrepancies between the facility's procedure and the audit criteria will need to be reconciled.

		MRSA ASH's data from the MRSA Auditing form (October 2007-February 2008) based on a 100% sample of individuals with MRSA each month (N=9) indicated 55% mean compliance with the requirement that the individual was placed on contact precautions per MRSA policy; 67% compliance with the requirement that the appropriate antibiotic was ordered for treatment of the infection(s); and 89% compliance with the requirement that the public health office contacted the unit RN and provided MRSA protocol and guidance for the care of the individual. ASH indicated that the low compliance regarding placement of contact precautions and appropriate antibiotic ordered was due to the site being healed by the time the culture results were received. Again, the discrepancies between the monitoring tool and policy/practice issues will need to be reconciled. HIV ASH's data from the HIV Positive Monitoring Form audit (October 2007-February 2008) based on a 100% sample of individuals HIV+ each month (N=8) indicated 100% compliance with the requirement that if the individual was admitted with a diagnosis of HIV+, a referral was made to the appropriate clinic during the admission; 100% compliance with the requirement that if the individual was diagnosed with HIV during hospitalization, a referral was made to the appropriate clinic; and 63% mean compliance with the requirement that the individual is seen by the appropriate clinic every three months for ongoing care and treatment, unless another timeframe is ordered by the physician. ASH's progress report indicated that the date of audit was did not allow sufficient time for the individual to have been seen in the clinic, which accounted for the low compliance rate. However, ASH did report that clinic appointments had been scheduled for each individual at the time of the audit.

		Recommendation 2, October 2007: Develop and implement a system to monitor and track the implementation of recommendations/corrective actions. **Findings:** Copies of audit results are included in the Executive Summaries that are presented at the Infection Control Committee and the EPPI Medical Services Team meetings. ASH reported that corrective action follow-up is currently not being tracked due to departmental workload demands. The department has been approved for an additional Public Health Service position, which is expected to be filled within the next six months for full implementation of this recommendation. **Current recommendations:** 1. Implement a system to monitor and track the implementation of recommendations/corrective actions. 2. Continue to monitor this requirement.
F.8.a.v	monitors to ensure that appropriate remedies are achieved; and	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Same as F.8.a.ii. **Findings:** <u>PPDs</u> ASH's data from the Admission PPD Monitoring Form audit (October 2007-February 2008) based on a 20% mean sample of PPDs due each month (N) indicated 3% mean compliance with the requirement that PPDs are administered by the nurse within 24 hours of the physician's order; 0% compliance with the requirement that first-step PPDs are read by the nurse within seven days of administration; and 0%

		compliance with the requirement that second-step PPDs are read by the nurse within 48-72 hours of administration. ASH reported that discrepancies between audit time frames and facility procedures accounted for low compliance rates. ASH's data from the Annual PPD Monitoring Form audit (October 2007-February 2008) based on a 20% mean sample of annual physical examinations due with PPD each month (N) indicated 0% mean compliance with the requirement that PPDs are administered by the nurse within 24 hours of the order and 100% mean compliance with the requirement that PPDs are read by the nurse between 48-72 hours after administration. Again, ASH indicated that discrepancies between audit requirements and facility procedures accounted for the low compliance rate regarding PPDs being administered within 24 hours or the order. ASH reported that there were no cases of active disease for individuals with positive PPDs for this review period. <u>Refusals</u> ASH's data from the Refusal Admission/Annual Lab Work or Diagnostic Test Auditing Form (October 2007-February 2008) based on a 57% mean sample of individuals who refused admission/annual lab work or PPD each month (N) indicated 75% mean compliance with the requirement that a Focus is opened for the Lab work or PPD refusal and 0% compliance with the requirement that appropriate objectives and interventions are written for the lab work or PPD refusal. ASH's data from the Immunization Refusal Audit Form (October 2007-February 2008) based on a 25% mean sample of individuals who refused immunizations each month (N) indicated 0% compliance with the

		requirements that a Focus is opened for the refusal of the immunization(s); appropriate objective(s) are developed for the refusal of immunization(s); and appropriate interventions are written for the objective(s) developed for the refusal of immunization(s). ASH has not yet implemented a system to ensure that refusals are addressed by the WRPTs and included in the WRPs. <u>Immunizations</u> ASH's data from the Immunization Monitoring Form audit (October 2007-February 2008) based on a 20% mean sample of immunizations each month (N) indicated 17% mean compliance with the requirement that immunizations are administered by the nurse within 24 hours of the physician's order and completed within specified timeframes. Discrepancies between audit requirements and facility procedures accounted for the low compliance rate regarding immunizations being administered within 24 hours of the order. <u>STDs</u> ASH's data from the Sexually Transmitted Disease Auditing Form (October 2007-February 2008) indicated that there were no newly identified cases of STDs during this review period. <u>MRSA</u> ASH's data from the MRSA Auditing Form (October 2007-February 2008) based on a 100% sample of individuals with MRSA each month (N=9) indicated 89% mean compliance with the requirement that a Focus 6 is opened for MRSA; 44% compliance that appropriate objectives are written to include prevention of spread of infection; and 44% compliance that appropriate interventions are written to include contact precautions.

		Hepatitis C ASH's data from the Hepatitis C Monitoring Form audit (October 2007-February 2008) based on a 71% mean sample of individuals Hepatitis C+ each month (N) indicated 84% mean compliance with the requirement that a Focus 6 is opened for Hepatitis C; 48% mean compliance with the requirement that appropriate objective(s) are written to include treatment as required by the Hepatitis C Tracking Sheet; and 48% mean compliance with the requirement that appropriate interventions are written to include treatment as required by the Hepatitis C Tracking Sheet. HIV ASH's data from the HIV Positive Monitoring Form audit (October 2007-February 2008) based on a 100% sample of individuals HIV+ (N=8) indicated 100% compliance with the requirement that a Focus 6 is opened for HIV (unspecified viral illness) if the individual is admitted with a diagnosis of HIV+; 88% compliance with the requirement that appropriate objective(s) are written to address the progression of the disease; and 88% compliance with the requirement that appropriate interventions are written. **Other findings:** This monitor's review of the charts of five individuals with a positive PPD (AW, DB, JC, DSC, JC and YVY) found that all had a chest x-ray in the chart and had it included in their WRPs as health maintenance. However, there was no indication that a positive PPD was included in the Axis III diagnoses for four individuals (DB, DSC, JC and YVY). This monitor reviewed the charts of 12 individuals who refused their PPDs and/or immunizations (AG, BR, DD, EMW, ES, JJG, JJM, JMO, LLD, MO, RD and RJL) and found that nine charts included an opened problem; however, six were listed as health maintenance and did not include any objectives or interventions addressing the refusals.

		This monitor reviewed the charts of seven individuals with MRSA (DVE, FVR, JFD, JG, LRS, LWH and NMK) and found that three individuals did not have an open Focus 6 addressing MRSA (FVR, JFD and JG). Although the remaining four individuals had an open Focus 6, three of the WRPs did not contain any objectives or interventions. The one WRP that did address MRSA (DVE) was noted to be inadequate. In addition, none of the seven individuals had the diagnosis of MRSA included in their Axis III diagnoses. Also, this monitor noted that there were a number of physician orders for "MRSA precautions;" however, discussion with the Infection Control staff revealed that there is no document at ASH that outlines MRSA precautions. This monitor reviewed the charts of 19 individuals with Hepatitis C (CMC, DB, DL, DWW, EJ, FJG, GAW, JCA, JF, JNL, JP, JSP, MM, RM, TAQ, TWS, VJA, WH and WS) and found that all had an open Focus 6 addressing Hepatitis C. However, only one WRP (WH) was noted to adequately address objectives and interventions. In addition, six did not include Hepatitis C in the Axis III diagnoses (CMC, EJ, GAW, JNL, JP and MM). This monitor reviewed the charts of five individuals with HIV (KFB, RH, RR, SB and TDW) and found that all had an open Focus 6 addressing unspecified viral illness. However, most of the objectives and interventions were generic and there was no indication that interventions were actually being implemented. The Clinic notes were detailed and indicated that the individuals were appropriately seen and followed. All had Unspecified Viral Illness listed in the Axis III diagnoses. In the areas of appropriate objectives and interventions for MRSA, Hepatitis C, HIV, and refusals, this monitor found lower compliance than ASH's data indicated. Discussion with the Infection Control staff

		who audits these areas, revealed that they rated compliance by the presence of objectives and interventions rather than by quality and appropriateness. It was agreed during this review that compliance would include quality and appropriateness of the WRPs addressing these areas. Data generated from the department consistently reflects a high level of compliance. However, the processes that are dependent on the WRPTs have accounted for a majority of the low compliance rates and are barriers to the department achieving substantial compliance in many areas. **Recommendation 2, October 2007:** Provide IT support to automate infection control data. **Findings:** ASH's progress report indicated that Public Health and IT collaborated to integrate infection surveillance into the existing Public Health database. A prototype of the software was developed and will be piloted at the end of April with implementation by May 30, 2008. **Current recommendations**: 1. Implement software for Infection Control as planned. 2. Continue to monitor this requirement.
F.8.a.vi	integrates this information into each State hospital's quality assurance review.	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Provide reports reflecting compliance with this requirement. **Findings:** The table data provided by ASH regarding this requirement could not be interpreted. However, the Infection Control Performance

		Improvement/Risk Assessment reports, summary reports of audit findings and corrective actions submitted to the Infection Control Committee, and minutes of the Department of Medicine (March 20, 2008) were provided for review. **Recommendation 2, October 2007:** Continue to monitor this requirement. **Findings:** This monitor's review of the Infection Control Performance Improvement/Risk Assessment reports, findings, follow-up and recommendations were specifically addressed. This monitor's review of the Department of Medicine minutes (March 20, 2008) found a brief mention of Infection Control regarding tetanus vaccinations and the Immunization Records for readmissions. This monitor was provided one meeting's minutes so has no indication if issues related to Axis III diagnoses were adequately addressed. In addition, no documentation was found indicating that Nursing was aware of the significant issues regarding WRPs for MRSA, Hepatitis C, and HIV. This monitor's review of the provided documentation found that there needs to be improvement in the integration of Infection Control throughout the facility, including risk management or quality assurance/improvement reviews. **Current recommendations:** Continue to provide data/reports/minutes addressing this requirement.

9. Dental Services		
	Each State hospital shall provide individuals with adequate, appropriate and timely routine and emergency dental care and treatment, consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: Nolan Nelson, DDS, Chief Dentist Reviewed: 1. Dental records for the following 56 individuals: AA, AC, AD, ALB, AQ, AR, BAL, BR, CMC, DB, DC, DGA, DS, EC, EEC, EVA, GC, GCJ, GG, HC, JB, JD, JEW, JJM, JKW, JMC, JMO, JR, JW, JZ, KT, LAP, LJ, MGW, MH, MJW, MMR, MS, MVF, NMK, PC, PCK, POB, PS, RD, RG, RTC, SA, SAB, SF, SMC, SRC, TLG, VB, WB and WDB 2. ASH's progress report and data 3. Memo dated 10/19/07 regarding After-Hours Dental Emergency Policy 4. Memo regarding Refused/Missed Dental Appointments 5. ASH Dental Health Care Plan (revised 3/29/08) 6. ASH Dental Care Services Monitoring Tool 7. Memo regarding Dental Record (MH 5505 A) photocopied and placed in medical record dated 8/2/07 8. Daily Sick Call of Dental Emergencies log 9. Dental Clinic Patient Refusal and Staff Response to Memo log
F.9.a	Each State hospital shall retain or contract with an adequate number of qualified dentists to provide timely and appropriate dental care and treatment to all individuals it serves;	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Implement revised policy addressing management of after-hours dental emergencies. **Findings:** ASH's progress report indicted that the new policy addressing after-hours dental emergencies was finalized on October 29, 2007. A memo outlining the changes in the policy was submitted by the facility

		indicating the new procedure. **Recommendation 2, October 2007:** Provide training to NODs regarding dental emergencies. **Findings:** ASH's progress report indicated that training addressing this recommendation occurred on November 1, 2007. **Recommendation 3, October 2007:** Continue to monitor and document incidents of inappropriate emergency dental care. **Findings:** This monitor's review and interview with Dr. Nolan Nelson, DDS, Chief Dentist found that there have been no incidents of inappropriate emergency dental care during this review period. In fact, ASH's data indicated that since the new Dental Emergency policy was implemented, 23 individuals were appropriately seen for after-hours dental emergency care. **Recommendation 4, October 2007:** Implement dental software package. **Findings:** Based on ASH's progress report and interview with the Chief Dentist, a dental software management system was approved for all DMH hospitals. Currently, the system is being evaluated as to how it will be integrated into the facility's system. **Recommendation 5, October 2007:** Continue to monitor this requirement.

		Findings: ASH's Chief Dentist reported that all dental positions have been filled. Since the last review, ASH has one Chief Dentist and two full-time dentists. In addition, there are three dental assistants. **Compliance:** Substantial. **Current recommendations:** Continue to monitor this requirement.
F.9.b	Each State hospital shall develop and implement policies and procedures that require:	**Compliance:** Partial.
F.9.b.i	comprehensive and timely provision of dental services;	**Current findings on previous recommendations:** **Recommendations 1 and 2, October 2007:** • Implement a statewide committee to review standards of practice and unification of documentation for dental services. • Develop and implement statewide monitoring instruments for dental services in alignment with the EP. **Findings:** At the time of this review, the Dental Department has been using its own monitoring tools. However, a statewide committee has met and monitoring tools have been developed and will be implemented for data collection after this review. **Recommendation 3, October 2007:** Continue to monitor this requirement. **Findings:** As mentioned above, ASH's data was generated by its monitoring tools;

		the facility plans to implement the statewide Dental Monitoring tools to collect data for the next review. ASH's data from the Dental Care Services Monitoring audit for October 2007-February 2008 based on a 100% sample of annual and admission dental exams due each month (N) indicated 40% mean compliance with the requirement that the individual was seen for an annual review within 30 days of the admission anniversary and 78% mean compliance with the requirement that the individual was seen within 90 days of admission. Although the data indicated that compliance rates increased each month of the review period, ASH reported that individuals who refuse annual and admission exams account are the main driver of low compliance rates. ASH data from the Provision of Timely Dental Care Log (October 2007- February 2008) based on a 100% sample of annual exams scheduled each month (N) indicated 30% mean compliance with the requirement that there was provision of dental treatment within 30 days of the annual exam. ASH data indicated that in February 2008, dental practice changed from performing the exam and scheduling a subsequent appointment to begin needed treatments to providing needed treatment on the day of the exam. This change in practice should increase compliance rates with this indicator by the next review. ASH's data from the Daily Sick Call Log (October 2007- February 2008) based on a 100% sample of emergency calls during clinic hours (N) indicated 100% compliance with the requirement that emergency call were responded to within 24 hours. This monitor's review of 14 individuals' admission dental exams (ALB, DGA, GCJ, JB, JEW, JMC, JMO, LAP, MJW, MVF, PCK, SRC, TLG and

		WDB) found that all but one (MVH) were seen within 90 days of admission. The documentation indicated that MVH refused the appointment. This monitor's review of 13 individuals' annual dental exams (AC, CMC, DB, EC, EVA, GC, JB, JR, JW, LJ, PC, RD and SMC), one was not timely seen (AC) and three were noted to have refused the appointments (CMC, EC and GC). **Current recommendations**: 1. Implement statewide monitoring tools. 2. Continue to monitor this requirement.
F.9.b.ii	documentation of dental services, including but not limited to, findings, descriptions of any treatment provided, and the plans of care:	**Current findings on previous recommendation:** **Recommendation 1, October 2007:** Ensure that all unit records have a copy of the Dental Clinic record. **Findings:** From the previous review ASH reported that copies of the dental clinic record were being placed in the individual's medical records to ensure consistency and accuracy in documentation. ASH has also added a Dental tab in the medical records and has obtained a color copier to accurately replicate the dental record. However, this monitor's review of 26 charts (AC, ALB, CMC, DB, DGA, EC, EVA, GC, GCJ, JB, JEW, JMC, JMO, JR, JW, LAP, LJ, MJW, MVF, PC, PCK, RD, SMC, SRC, TLG and WDB) found inconsistent documentation of appointments in all 26 medical records as compared to the dental records. In addition, there were inconsistencies in the documentation in the Physician Progress Notes regarding dental care and appointments as compared to the medical records and dental clinic records. Based on discussion with Dr. Nelson, the dentists are still writing in the progress notes, which duplicates the information from the dental records. This issue needs

		to be reassessed since dental now has a section clearly marked in the medical records. **Recommendation 2, October 2007:** Same as recommendations in F.b.9.i. **Findings:** ASH's data from the Dental Care Services Monitoring audit (October 2007- February 2008) based on a 27% mean sample of dental clinic visits each month (N) indicated 98% mean compliance with the requirement that a description of the findings was noted; 98% mean compliance with the requirement that a description of treatment provided was noted; and 98% mean compliance with the requirement that a description of the plan of care was noted. This monitor's review of 14 individuals (ALB, DGA, GCJ, JB, JEW, JMC, JMO, LAP, MJW, MVF, PCK, SRC, TLG and WDB) found that all but one, who had refused the exam (MVF), contained a description of findings, the treatment provided at the appointment, and a specific plan of care. The implementation of the DMH WRP Dental Treatment Plan Update form has significantly clarified the treatment plan and treatment provided for individuals. **Current recommendations**: 1. Evaluate the need for duplication of dental documentation. 2. See F.9.b.i
F.9.b.iii	use of preventive and restorative care whenever possible; and	**Current findings on previous recommendations:** **Recommendation, October 2007:** Same as recommendations in F.b.9.i.

		Findings: According to ASH's data (October 2007- February 2008), the facility reported 100% compliance for preventative dental care based on a 47% mean sample of annual dental exams (N). However, the data regarding restorative dental care could not be accurately be interpreted since the data indicated that only records for those individuals who received restorative care were reviewed. Thus, the data yielded 100% compliance. This monitor's review of 14 individuals (ALB, DGA, GCJ, JB, JEW, JMC, JMO, LAP, MJW, MVF, PCK, SRC, TLG and WDB) found that 13 had documentation of preventative care and initiation of restorative care. One individual had refused the exam (MVF). **Current recommendations**: See F.9.b.i.
F.9.b.iv	tooth extractions be used as a treatment of last resort, which, when performed, shall be justified in a manner subject to clinical review.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Same as recommendations in F.b.9.i. **Findings:** ASH's data from the Dental Care Services Monitoring audit (October 2007- February 2008) based on a 47% mean sample of tooth extractions each month (N) indicated 87% mean compliance with the requirement that a justification is noted for tooth extraction; 87% mean compliance with the requirement that it was noted as the treatment of last resort; and 87% mean compliance with the requirement that a description of treatment was provided. ASH's progress report indicated that compliance rates for these indicators dropped in November and December 2007 due to new

		dentists and that the increase in compliance in subsequent months was due to training regarding documentation requirements. This monitor's review of the documentation for 13 individuals who had tooth extractions (AD, BAL, EEC, JB, JJM, JKW, JMC, KT, MGW, MMR, NMK, RTC and SAB) found the specific criteria justifying the extraction in all cases. **Current recommendations:** See F.9.i.
F.9.c	Each State hospital shall ensure that dentists demonstrate, in a documented fashion, an accurate understanding of individuals' physical health, medications, allergies, and current dental status and complaints.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Same as recommendations in F.b.9.i. **Findings:** ASH's data from the Dental Care Services Monitoring audit (October 2007- February 2008) based on a 26% mean sample of individuals who received comprehensive dental exams or follow-up dental care each month (N) indicated 92% mean compliance with the requirement that a the individual's physical health/medical conditions were reviewed and noted; 92% mean compliance that the individual's medications were reviewed and noted; 92% mean compliance with the requirement that the individual's allergies were reviewed and noted; and 96% mean compliance with the requirement that the individual's current dental status was reviewed and noted. This monitor's review of 26 charts (AC, ALB, CMC, DB, DGA, EC, EVA, GC, GCJ, JB, JEW, JMC, JMO, JR, JW, LAP, LJ, MJW, MVF, PC, PCK, RD, SMC, SRC, TLG and WDB) found that all but those of four individuals who had refused the appointments (CMC, EC, GC and MVF) contained documentation of a review of physical health/medical

		conditions, medications, allergies, and dental status. **Compliance:** Substantial. **Current recommendations:** Continue current practice.
F.9.d	Each State hospital shall ensure that transportation and staffing issues do not preclude individuals from attending dental appointments, and individuals' refusals are addressed to facilitate compliance.	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Develop and implement a system to monitor and track issues that preclude individuals from attending dental appointments. **Findings:** The Dental Department maintains a log to track refusals and staff response to memos sent by the department notifying the units of refused appointments. However, transportation and staffing issues are not included in this log. **Recommendation 2, October 2007:** Implement strategies to increase unit responses to refusal memos. **Findings:** The Department met with the Program Directors regarding reviewing the memos sent by the Dental Department for refusal of treatment. Previously these memos were e-mailed to program directors and are now being faxed since February 2008. **Recommendation 3, October 2007:** Continue to monitor this requirement.

		Findings: ASH's data from the Dental Care Services Monitoring audit (October 2007- February 2008) based on a 97% mean sample of individuals who refused dental treatments each month (N) indicated 7% mean compliance with the requirement that for individuals not seen, was there a reason and a follow-up noted by unit staff and communicated to the Dental Clinic. The data indicates clearly that there is not a reliable system in place addressing individuals refusing dental appointments. **Compliance:** Noncompliance. **Current recommendations:** 1. Present data addressing all elements of this requirement. 2. Develop and implement a system to facilitate compliance for individuals refusing dental appointments.
F.9.e	Each State hospital shall ensure that interdisciplinary teams review, assess, and develop strategies to overcome individual's refusals to participate in dental appointments.	**Current findings on previous recommendations:** **Recommendations 1 and 2, October 2007:** • See F.9.d, Recommendation 2. • Continue to monitor this requirement. **Findings:** This monitor's review of 20 individuals who refused dental appointments (AA, AQ, AR, BR, DC, DS, GG, HC, JD, JZ, MH, MS, PC, POB, PS, RG, SA, SF, VB and WB) found no indication that the WRPTs review, assess, and develop strategies to overcome individuals' refusals to participate in dental appointments. No progress has been made since the last review regarding this

		requirement. The Dental Department has continued to send the refusal memos to the units. However, there have been no actions implemented by the WRPTs addressing this issue. **Compliance:** Noncompliance. **Current recommendations**: Develop and implement a system to facilitate compliance for individuals refusing dental appointments.

G. Documentation		
G	Each State hospital shall ensure that an individual's records accurately reflect the individual's response to all treatment, rehabilitation and enrichment activities identified in the individual's therapeutic and rehabilitation service plan, including for children and adolescents, their education plan, consistent with generally accepted professional standards of care. Each State hospital shall develop and implement policies and procedures setting forth clear standards regarding the content and timeliness of progress notes, transfer notes, school progress notes, and discharge notes, including, but not limited to, an expectation that such records include meaningful, accurate, and coherent assessments of the individual's progress relating to treatment plans and treatment goals, and that clinically relevant information remains readily accessible.	Specific judgments regarding the quality of documentation, as well as progress towards substantial EP compliance and remaining deficiencies, are contained in the discipline-specific subsections of Sections D and F, as well as in Sections E and H. Please refer to these sections for findings (including compliance) and recommendations pertaining to documentation

H. Restraints, Seclusion, and PRN and Stat Medication		
H		**Summary of Progress:** 1. ASH implemented the DMH statewide monitoring tools for this section in March 2008. 2. Much of the data regarding restraints and seclusion provided by ASH for this review is in alignment with current practices. 3. ASH has 85% or greater compliance regarding staff training for PMAB and certification for medication administration and for the conduct of assessments by a physician or other licensed professional within one hour of restraint/seclusion episodes.
H	Each State hospital shall ensure that restraints, seclusion, psychiatric PRN medications, and Stat medications are used consistent with generally accepted professional standards of care.	**Methodology:** <u>Interviewed</u>: 1. Donna Nelson, Standards Compliance Director 2. Rosemary Morrison, Health Services Specialist 3. Judith Boyer, Standards Compliance 4. Vickie Vinke, Health Services Specialist Central Nursing Services 5. Stan Wilt, RN Central Nursing Services <u>Reviewed</u>: 1. AD #518, Restraint Or Seclusion; AD 418, Key Indicator/Trigger Reporting effective 1/15/08; 2. The DMH Psychology Services Monitoring form instructions 3. Memo dated 1/22/08 regarding Psychiatric PRN time limits 4. Restraint and Seclusion Documentation class objectives 5. ASH Restraint and Seclusion Monitoring tool instructions 6. ASH training database 7. Behavior guidelines for the following individuals: AA, AB, AJ, CE, CG, DC, DY, ED, ER, GF, GG, IW, JP, JR, JS, JT, KH, LJ, MA, MB, MN, RS, SM and VL 8. Medical records for the following individuals: AB, AD, AJ, BG, CW,

		DGM, DP, EDM, GRF, GS, JF, JLF, JS, MC, MJC, MR, MW, OR, RDC, RH, RS, RSP, SNL, SU, TJS, TP, WST and ZDS
H.1	Each State hospital shall revise, as appropriate, and implement policies and procedures regarding the use of seclusion, restraints, psychiatric PRN medications, and Stat Medications consistent with generally accepted professional standards of care. In particular, the policies and procedures shall expressly prohibit the use of prone restraints, prone containment and prone transportation and shall list the types of restraints that are acceptable for use.	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Prohibit staff from using fading techniques regarding seclusion and restraints. **Findings:** ASH's progress report indicated that according to its policies, the staff is not allowed to use the practice of fading regarding restraints. ASH included in the progress report the statement that, "However there may be instances when staff has to utilize intermediate interventions for safety reasons." A review of a restraint episode for EDM indicated that the practice of fading was still being used at ASH. This monitor's discussion with the staff who attended the Seclusion and Restraint interview reiterated there is to be no use of fading at the facility. **Recommendation 2, October 2007:** Ensure all policies/procedures prohibit the use of fading regarding seclusion and restraints. **Findings:** ASH's progress report indicated that AD #518 was revised, prohibiting use of fading restraints, and was approved on October 18, 2007. However, this monitor's review of AD #518 did not find the use of fading addressed as indicated by ASH. **Recommendation 3, October 2007:** Continue to monitor this requirement.

		Findings: ASH's data for this review was generated by the facility's monitoring tools since the facility has only recently begun to use the DMH monitoring tools in March 2008. The data for this requirement could not be interpreted. This monitor's review of 22 individuals who were placed in restraint and/or seclusion (AB, AD, AJ, BG, CW, EDM, GRF, JF, JLF, JS, MC, MJC, MR, RDC, RH, RS, RSP, SNL, TJS, TP, WST and ZDS) found that on 2/28/08, GRF was placed in handcuffs by the facility police, transported on a gurney in prone position and then placed in restraints. There was no indication in this monitor's interview for this section that ASH's staff was aware of this situation and had reviewed the incident. After the on-site tour was completed, information was provided to this monitor indicating that staff had in fact reviewed the incident. However, the staff's interpretation of the event was that it constituted prone stabilization, when the documentation reviewed by this monitor clearly indicated that prone containment and prone transportation were used, contrary to ASH's current policy. **Compliance:** Partial. **Current recommendations**: 1. Ensure all policies/procedures prohibit the use of fading regarding seclusion and restraints. 2. Identify any individuals who have been placed in prone restraints, prone containment and/or a prone position for transportation for each review period. 3. Provide appropriate data for this requirement 4. Continue to monitor this requirement. .

H.2	Each State hospital shall ensure that restraints and seclusion:	**Compliance:** Partial.
H.2.a	are used in a documented manner and only when individuals pose an imminent danger to self or others and after a hierarchy of less restrictive measures has been considered in a clinically justifiable manner or exhausted;	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Provide data reflecting this requirement. **Findings:** ASH's data from the ASH Restraint Monitoring Audit Form (October 2007-February 2008) based on an 86% mean sample of restraint episodes (N) indicated 90% mean compliance with the requirement that restraint was used only when an individual posed an imminent danger to self or others, and 56% mean compliance with the requirement that restraint was used only after a hierarchy of less restrictive measures had been exhausted. ASH's data from the ASH Seclusion Monitoring Audit Form (October 2007-February 2008) based on a 95% mean sample of seclusion episodes (N) indicated 86% mean compliance with the requirement that restraint was used only when an individual posed an imminent danger to self or others, and 64% mean compliance with the requirement that restraint was used only after hierarchy of less restrictive measures had been exhausted. This monitor's review of 40 episodes of restraint for 20 individuals who were placed in restraint and/or seclusion (AB, AJ, BG, DP, EDM, GRF, JLF, JS, MC, MJC, MR, MW, RDC, RH, RS, RSP, TJS, TP, WST and ZDS) found that the documentation for 32 episodes supported the decision to place the individual in restraints. Less restrictive alternatives attempted were documented in 18 episodes. This monitor also found inconsistencies in documentation regarding the time an individual was actually placed in restraints.

		This monitor's review of 15 episodes of seclusion for 12 individuals (AJ, CW, GRF, JS, MJC, MW, OR, RH, SNL, SU, TJS and ZDS) found that the documentation in nine episodes indicated the specific reason for the placement and that alternative measures were documented in two of the episodes. ASH's progress report indicated that in January 2008, a mandatory restraint and seclusion documentation class was implemented. The class includes a section on policy and procedure that focused on the expectation that restraint or seclusion is the last resort in the hierarchy of managing behaviors. ASH indicated that the impact of this class was reflected in the increased compliance in their data throughout Section H. **Recommendation 2, October 2007:** Continue to monitor this requirement. **Findings:** Same as above. **Current recommendation**: Continue to monitor this requirement using the DMH monitoring tools.
H.2.b	are not used in the absence of, or as an alternative to, active treatment, as punishment, or for the convenience of staff;	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Initiate a system to review the WRPs of individuals frequently placed in seclusion and restraints to ensure that alternative strategies are being addressed by the teams. **Findings:** This monitor's review of AD #418, Key Indicator/Trigger Reporting

		effective 1/15/08 found that it adequately outlines the requirements for morning trigger meetings in each program and outlines the function of the Enhanced Trigger Review Committee (ETRC). Thus, individuals who meet the threshold for restraint and seclusion will be reviewed at the daily program trigger review meeting and weekly in the ETRC, which includes review of WRPs. **Recommendation 2, October 2007:** Ensure that progress notes are reviewed along with SIRs in monitoring this requirement. **Findings:** ASH indicated that review of the progress notes is included in all Restraint/Seclusion audits. **Recommendation 3, October 2007:** Continue to monitor this requirement. **Findings:** ASH's data from the ASH Restraint Monitoring Form audit (October 2007-February 2008) based on an 85% mean sample of restraint episodes (N) indicated 81% mean compliance with the requirement that restraint was not used in absence of or as an alternative to active treatment; 95% mean compliance with the requirement that restraint was not used as punishment; and 96% compliance with the requirement that restraint was not used for the convenience of staff. ASH's data from the ASH Seclusion Monitoring Form audit (October 2007-February 2008) based on an 95% mean sample of seclusion episodes (N) indicated 84% mean compliance with the requirement that seclusion was not used in absence of or as an alternative to active treatment; 96% mean compliance with the requirement that seclusion was not used as punishment; and 93% compliance with the requirement

		that seclusion was not used for the convenience of staff. Additionally, see H.2.a. **Other findings:** This monitor's review of 20 Review of Activated Trigger sheets found that aside from the check marks indicating a review, none had specific documentation contained in the Additional Notes/Comments/ Justification sections. **Current recommendation**: Continue to monitor this requirement.
H.2.c	are not used as part of a behavioral intervention; and	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Clarify data to reflect this requirement. **Findings:** The DMH Psychology Services Monitoring form instructions adequately address this recommendation. **Recommendation 2, October 2007:** Continue to monitor this requirement. **Findings:** ASH's data indicated that based on a review of all the behavioral guidelines hospital-wide from September 2007-February 2008, none included the use of aversive or punishment contingencies. This monitor's review of 24 individuals' behavior guidelines (AA, AB, AJ, CE, CG, DC, DY, ED, ER, GF, GG, IW, JP, JR, JS, JT, KH, LJ, MA, MB, MN, RS, SM and VL) found that none contained the use of restraints or seclusion.

		Current recommendation: Continue to monitor this requirement.
H.2.d	are terminated as soon as the individual is no longer an imminent danger to self or others.	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Ensure that training regarding seclusion and restraints prohibits the use of fading. **Findings:** ASH's progress report indicated that this requirement is taught in PMAB and restraint /Seclusion documentation classes. However, there was no supporting documentation verifying this. This monitor's review of the Restraint and Seclusion Documentation class objectives found no indication that fading was addressed. **Recommendation 2, October 2007:** Ensure that exit criteria for seclusion and restraints contained in physicians' orders are specific and individualized. **Findings:** ASH's progress report indicated that the medical director issued a memo instructing all psychiatrists to include exit criteria in restraint and seclusion orders and that the Psychiatry Manual was revised to include language outlining exit criteria for restraint and seclusion. However, no supporting data was provided by ASH verifying these actions. **Recommendation 3, October 2007:** Continue to monitor this requirement.

		Findings: ASH's data from the ASH Restraint Monitoring Form audit (October 2007-February 2008) based on an 85% mean sample of restraint episodes (N) indicated 83% mean compliance with the requirement that restraint was terminated as soon as the individual was no longer an imminent danger to self or others. ASH's data from the ASH Seclusion Monitoring Form audit (October 2007-February 2008) based on a 95% mean sample of seclusion episodes (N) indicated 81% mean compliance with the requirement that seclusion was terminated as soon as the individual was no longer an imminent danger to self or others. This monitor's review of 40 episodes of restraints for 20 individuals who were placed in restraint and/or seclusion (AB, AJ, BG, DP, EDM, GRF, JLF, JS, MC, MJC, MR, MW, RDC, RH, RS, RSP, TJS, TP, WST and ZDS) found that the documentation for 30 episodes supported the decision to terminate the use of restraints. The review found a number of examples of individuals sleeping in restraints and being allowed to get up and take a shower but then placed back into restraints without justification. This monitor's review of 15 episodes of seclusion for 12 individuals (AJ, CW, GRF, JS, MJC, MW, OR, RH, SNL, SU, TJS and ZDS) found that the documentation in 10 episodes supported the decision to terminate the use of seclusion. **Current recommendations**: 1. Provide supporting data for Recommendations 1 and 2. 2. Continue to monitor this requirement.
H.3	Each State hospital shall comply with 42 C.F.R. § 483.360(f), requiring assessments by a physician or	**Current findings on previous recommendation:**

	licensed clinical professional of any individual placed in seclusion or restraints within one hour. Each State hospital shall also ensure that any individual placed in seclusion or restraints is continuously monitored by a staff person who has successfully completed competency-based training on the administration of seclusion and restraints.	**Recommendation 1, October 2007:** Provide data regarding competency-based training. **Findings:** ASH's data from the ASH Training Database for September 2007-February 2008 indicated that 95% of all nursing staff has attended Prevention and Management of Assaultive Behavior (PMAB) training every two years. **Recommendation 2, October 2007:** Continue to monitor this requirement. **Findings:** ASH's data from the ASH Restraint Monitoring Form audit (October 2007-February 2008) based on an 85% mean sample of restraint episodes (N) indicated 87% mean compliance with the requirement that the individual in restraints was assessed by a physician or registered nurse or licensed clinical professional within one hour. ASH's data from the ASH Seclusion Monitoring Form audit (October 2007-February 2008) based on a 95% mean sample of seclusion episodes (N) indicated 88% mean compliance with the requirement that the individual in seclusion was assessed by a physician or registered nurse or licensed clinical professional within one hour. This monitor's review of a total of 55 episodes of restraints and seclusion found that 53 had documentation that assessments were conducted by a physician or licensed clinical professional within one hour. **Compliance:** Substantial.

		Current recommendation: Continue to monitor this requirement.
H.4	Each State hospital shall ensure the accuracy of data regarding the use of restraints, seclusion, psychiatric PRN medications, or Stat medications.	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Expand data monitoring to additional programs. **Findings:** ASH's progress report indicated that restraint and seclusion has been monitored hospital-wide. **Recommendations 2 and 3, October 2007:** • Evaluate reasons for low accuracy rates for seclusion and restraint data. • Provide data regarding accuracy of Stat data. **Findings:** ASH indicated that in July of 2007, Standards Compliance took over auditing for restraint/seclusion to ensure accuracy of data. **Recommendation 4, October 2007:** Continue to monitor this requirement. **Findings:** ASH's data from the ASH Restraint Monitoring Form audit (October 2007-February 2008) based on an 85% mean sample of restraint episodes (N) indicated 81% mean compliance with the requirement that the restraint event start and stop time match the ORYX report data. ASH's data from the ASH Seclusion Monitoring Form audit (October 2007-February 2008) based on a 95% mean sample of Seclusion Episodes (N) also indicated 85% mean compliance with the requirement

		that the restraint event start and stop time match the ORYX report data. ASH's data from the Nursing Administration of PRN Medication Monitoring (October 2007-February 2008) based on a 23% mean sample of behavioral PRNs administered on Program IV for October - December 2007 and hospital-wide for January and February 2008 (N) indicated 85% mean compliance with the requirement that the medical record documentation matched the PRN data from Quick Hits. ASH's data from the Nursing Administration of Stat Medication Monitoring (October 2007-February 2008) based on a 28% mean sample of behavioral Stats administered on Program IV for October - December 2007 and hospital-wide for January and February 2008 (N) indicated 84% mean compliance with the requirement that the medical record documentation matched the Stat data from Quick Hits. **Compliance:** Partial. **Current recommendation**: Continue to monitor this requirement.
H.5	Each State hospital shall revise, as appropriate, and implement policies and procedures to require the review within three business days of individuals' therapeutic and rehabilitation service plans for any individuals placed in seclusion or restraints more than three times in any four-week period, and modification of therapeutic and rehabilitation service plans, as appropriate.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Continue to monitor this requirement. **Findings:** ASH's data from the ASH Restraint Monitoring Form audit (October 2007-February 2008) based on an 84% mean sample of instances that this Restraint trigger was met (N) indicated 63% mean compliance with the requirement that the staff review the individual's WRP within

		three business days for more than three episodes of restraint in any four-week period, and 48% mean compliance with the requirement that the WRP was modified appropriately pursuant to the mini team review regarding the restraints. ASH's data from the ASH Seclusion Monitoring Form audit (October 2007-February 2008) based on an 86% mean sample of instances that this seclusion trigger was met (N) indicated 78% mean compliance with the requirement that the staff review the individual's WRP within three business days for more than three episodes of seclusion in any four-week period, and 72% mean compliance with the requirement that the WRP was modified appropriately pursuant to the mini team review regarding the seclusions. This monitor's review of 10 individuals (AB, AD, BG, GRF, GS, JF, MC, MW, RDC and ZDS) who had three or more restraint/seclusion episodes in four weeks found that Trigger Reviews were found in the medical records. However, they contained little to no meaningful information. **Compliance:** Partial. **Current recommendation**: Continue to monitor this requirement.
H.6	Each State hospital shall develop and implement policies and procedures consistent with generally accepted professional standards of care governing the use of psychiatric PRN medication and Stat medication, requiring that:	**Compliance:** Partial.

H.6.a	such medications are used in a manner that is clinically justified and are not used as a substitute for adequate treatment of the underlying cause of the individual's distress.	**Current findings on previous recommendation:** **Recommendation 1, October 2007:** Continue to provide training to staff regarding the appropriate use and documentation of PRN and Stat medications. **Findings:** ASH has added Competency-Based Restraint/Seclusion Documentation to the facility's mandatory training. This was implemented in January 2008 and 499 nursing staff has received the training as of 4/4/08. The curriculum for this class verified that documentation was included in the training. **Recommendation 2, October 2007:** Provide minutes of the trigger meetings. **Findings:** No minutes of the trigger meetings were provided by the facility addressing this recommendation. **Recommendation 3, October 2007:** Continue to monitor this requirement. **Findings:** ASH's data from the Nursing Administration of PRN Medication Monitoring Form audit (October 2007-February 2008) based on an 26% mean sample of behavioral PRN medications used hospital-wide (N) indicated 52% mean compliance with the requirement that behavioral PRNs are used in a manner that is clinically justified, and 23% mean compliance with the requirement that behavioral PRNs are not used as a substitute for adequate treatment of the underlying cause of the individual's distress.

		ASH's data from the Nursing Administration of Stat Medication Monitoring Form audit (October 2007-February 2008) based on a 32% mean sample of behavioral Stat medications used hospital-wide (N) indicated 48% mean compliance with the requirement that behavioral Stats are used in a manner that is clinically justified, and 34% mean compliance with the requirement that behavioral Stats are not used as a substitute for adequate treatment of the underlying cause of the individual's distress. ASH's progress report indicated that the documentation issues regarding PRN and Stat medications have been presented to the Master WRP Trainer and the WRP EPPI team and will be a focus of further training for the mentors. See also F.3.a.ii. **Other findings:** A review of the charts of three individuals (AD, GRF and RS) was conducted regarding PRN/Stat medications in relation to the individuals' incidents of seclusion/restraints. The review focused on the nurses' clinical decisions regarding PRN/Stat medication use and the resulting impact on the seclusion/restraint event. In the case of GRF, the interdisciplinary note (IDN) on 12/7/07 indicated that his speech was rapid and pressured and that he demanded placement in seclusion. However, no PRN was offered at that time and he was placed in seclusion. In addition, there was no documentation that other interventions were tried. While the documentation indicated that GRF was able to identify feeling out of control, there was no indication that his team had developed strategies to assist GRF when this occurred.

		Additional issues for GRF: 1. A number of IDNs were out of order. 2. IDNs refer to a PRN that was given prior to the seclusion episode; however, the name of the medication, the route, the dosage, and the actual time given was not documented. 3. An IDN for 12/8/07 indicates that GRF had been sleeping for the past few hours and had not been released from seclusion. In the case of RS, the IDN for 2/28/08 indicated that he had been agitated and cursing at staff and peers. He was offered a PRN; however, it was unclear from the notes if he had actually received one. He was kept in restraints until 3/1/08 but was not given a PRN or Stat medication during this period of time. In addition, the notes indicated that he was asked to go to his room to calm down, which he did although he continued to yell and threaten staff. He was then told to come out of his room and when he refused, staff and the hospital police entered his room. The notes then indicate that he refused to calm down, making it impossible to apply leather restraints, and was handcuffed by hospital police. He was placed on a backboard and gurney in prone position for transport to full bed restraints. Clearly, additional medications (PRN and/or Stat) given at the first signs of his agitation or at least during the course of restraint may have shortened the duration of the restriction. Additional issues for GS: 1. Activated Trigger forms contain little meaningful information. 2. Seclusion/Restraint Debriefing forms for 2/28/08 and 3/1/08 are basically identical. In the case of AD, the IDN on 2/23/08 indicated that he made a threat to staff in a calm, matter-of-fact manner. The IDN stated that he was encouraged to return to playing bingo. Ten minutes later, he was placed in restraints after telling an officer the same thing. There

		was no indication that he was displaying out-of-control behaviors to warrant the use of restraints. Although the documentation did not support the use of restraints, had the staff member responded to AD's statement with an assessment of the situation, it may have averted the use of restraints. Overall, due to the inadequate documentation, it was difficult if not impossible to determine if and when an individual actually received a PRN or Stat medication in situations in which restraint and/or seclusion were used. **Current recommendations:** 1. Ensure that documentation for PRN and Stat medication in the IDNs is in alignment with generally accepted standards of nursing practice. 2. Continue to monitor this requirement.
H.6.b	PRN medications, other than for analgesia, are prescribed for specified and individualized behaviors.	**Current findings on previous recommendation:** **Recommendations 1 and 2, October 2007:** • Ensure that PRN medications, other than for analgesia are prescribed for specific and individualized behaviors. • Continue to monitor this requirement. **Findings:** ASH's data from the DMH Monthly PPN Audit Form based on a 6% mean sample of individuals in the facility 90 days or more (January-February 2008) indicated 17% mean compliance with the requirement for timely review of the use of "pro re nata" or "as needed" (PRN) and "Stat" (i.e. emergency psychoactive) medications and adjustment of regular treatment, as indicated, based on such use. This monitor's review of PRN orders for 20 individuals (AB, AJ, BG, DP,

		EDM, GRF, JLF, JS, MC, MJC, MR, MW, RDC, RH, RS, RSP, TJS, TP, WST and ZDS) found that most of the orders were not written for specific behaviors. **Current recommendation**: Continue to monitor this requirement.
H.6.c	PRN medications are appropriately time limited.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Continue to monitor this requirement. **Findings:** ASH initiated a change effective February 4, 2008 limited all psychiatric PRN medication orders to 14 days. Beginning in May 2008, Standards Compliance will begin to audit for this change and the Pharmacy will initiate a medication variance report when orders do not follow this guideline. **Current recommendation**: Implement monitoring for this requirement.
H.6.d	nursing staff assess the individual within one hour of the administration of the psychiatric PRN medication and Stat medication and documents the individual's response.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Continue to monitor this requirement. **Findings:** ASH's data from the Nursing Administration of PRN Medication Monitoring Form audit (January -February 2008) based on an 26% mean sample of behavioral PRN medications administered (N) indicated 35% mean compliance with the requirement that there is a brief description in the MTR of the individual's response to the administered

		PRN medication and 49% mean compliance with the requirement that the brief description was documented within one hour of the administration. ASH's data from the Nursing Administration of Stat Medication Monitoring Form audit (January-February 2008) based on an 32% mean sample of behavioral Stat medications administered (N) indicated 17% mean compliance with the requirement that there is a brief description in the MTR of the individual's response to the administered Stat medication and 29% mean compliance with the requirement that the brief description was documented within one hour of the administration. ASH has revised NP 307.0.1 in April of 2008 requiring documentation in the both the MTR and IDN within one hour of administration. The training addressing this revision is to be completed by May 30, 2008. See also F.3.a.iii. **Current recommendation**: Continue to monitor this requirement.
H.6.e	A psychiatrist conducts a face-to-face assessment of the individual within 24 hours of the administration of a Stat medication. The assessment shall address reason for Stat administration, individual's response, and, as appropriate, adjustment of current treatment and/or diagnosis.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Same as in D.1.f, F.1.b and H.6.a. **Findings:** Same as in D.1.f, F.1.b and H.6.a. **Current recommendations**: Same as in D.1.f, F.1.b and H.6.a.

H.7	Each State hospital shall ensure that all staff whose responsibilities include the implementation or assessment of seclusion, restraints, psychiatric PRN medications, or Stat medications successfully complete competency-based training regarding implementation of all such policies and the use of less restrictive interventions.	**Current findings on previous recommendations:** **Recommendations 1 and 2, October 2007:** • Provide data regarding monitoring system addressing this requirement. • Continue to monitor this requirement. **Findings:** Data from ASH's Training Database indicated 87% compliance with the requirement that staff are who are required to be Medication Certified have been certified in Psychiatric or Stat medication use and less restrictive interventions. See also H.3. **Compliance:** Substantial. **Current recommendation:** Continue current practices regarding this requirement.
H.8	Each State hospital shall:	**Compliance:** Partial.
H.8.a	develop and implement a plan to reduce the use of side rails as restraints in a systematic and gradual way to ensure individuals' safety; and	**Current findings on previous recommendation:** **Recommendation, October 2007:** Continue to monitor this requirement. **Findings:** At the time of this review, there were no individuals at ASH with side rails as a restraint. ASH uses the split-type side rails in the infirmary unit and has also purchased 15 electric beds that can be lowered to close to ground level.

		Current recommendation: Continue to monitor this requirement.
H.8.b	ensure that, as to individuals who need side rails, their therapeutic and rehabilitation service plans expressly address the use of side rails, including identification of the medical symptoms that warrant the use of side rails, methods to address the underlying causes of such medical symptoms, and strategies to reduce the use of side rails, if appropriate.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Continue to monitor this requirement. **Findings:** ASH reported that during the review period, the facility cared for one individual (DGM) who was at risk for falls during the night. Although the facility indicated that he had the split-type side rails, this monitor's review of the individual's chart found that the documentation was not consistently clear regarding how many side rails were elevated and if he was able to elevate or put down the side rails without staff assistance. This type of documentation is essential in demonstrating that the use of side rails does not constitute a form of restraint. The individual expired on February 17, 2008 and there were no other individuals meeting this criterion at the time of the tour. **Current recommendations**: 1. Ensure adequate documentation regarding the use of side rails. 2. Continue to monitor this requirement.

I. Protection from Harm		
I	Each State hospital shall provide the individuals it serves with a safe and humane environment and ensure that these individuals are protected from harm.	**Summary of Progress:** 1. The investigations completed by the Office of Special Investigations and the Department of Police Services (DPS) have improved considerably. There is evidence in some of the investigations reviewed of attempts to find additional witness, the use of clinical assistance when necessary, the use of the revised definitions of abuse and neglect, alertness and questioning to the possibility of fear of retaliation on the part of a reporter of an allegation, and the inclusion and docketing of relevant documentation from various sources, including the clinical record of the individual involved. 2. The DPS Record Management System has been operational for about a year. It is capable of providing trend and pattern data once the facility is assured that the information is accurate. 3. The Incident Management Review Committee has expanded its duties to include the review of investigations of abuse and neglect and HQ Reportable Briefs. It expects to begin reviewing trend and pattern data in May 2008. 4. DMH has raised the priority level for the development and implementation of a department-wide data system for incident management. 5. The facility has developed a system for identifying all individuals who have reached behavioral triggers in all programs and for alerting their WRPTs. A multi-disciplinary review of Level 2 triggers occurs weekly, directed by the Chief of Psychiatry. This Enhanced Trigger Response Review Committee provides a forum for the review of the relevant portions of the individual's WRP and an opportunity to track the progress/status of individuals who repeatedly reach these targets. 6. The facility has initiated a Mortality Interdisciplinary Review Committee (MIRC) in response to Special Order 205.05.

		Clarification of the roles of the Mortality and Morbidity (M&M) Committee and the MIRC is presently occurring and should strengthen the facility's reviews of deaths. 7. In response to critical incidents and the rise in peer violence, the facility has undertaken a Violence Abatement Project. The work includes the formation of a committee to analyze causal factors and research best practices to develop recommendations related to the reduction of aggression/assault incidents; environmental changes; consideration of video surveillance cameras; consideration of a special unit for chronically violent individuals; and review of the integration of work and data sources for the Health and Safety Program, the Incident Management Review Committee and other bodies to recommend improvements that will ensure an organized proactive risk management system.

1. Incident Management		
I.1	Each State hospital shall develop and implement across all settings, including school settings, an integrated incident management system that is consistent with generally accepted professional standards of care.	**Methodology:** Interviewed: 1. J. DeMorales, Executive Director 2. R. Knapp, MD, Medical Director 3. D. Fennell, MD, Chair, Mortality and Morbidity Committee 4. J. Dansereau, MD, Chief of Psychiatry 5. D. Landrum, Police Lieutenant 6. D. Nelson, Director, Standards Compliance 7. L. Persons, Hospital Administrator 8. S. Joslin, Standards Compliance 9. C. Williams, Standards Compliance 10. R. Harmon, DPS Lieutenant, Records Management System Reviewed: 1. Seventeen investigations completed by the Office of the Special Investigator (OSI) 2. Five investigations completed by the Department of Police Services (DPS) 3. Three death investigation reports 4. Seven HQ Reportable Briefs 5. Clinical records of aggressor and victim in 3/30/08 death 6. Mortality Review Committee minutes for 2007 to the present 7. Mortality Interdisciplinary Review Committee minutes 8. Incident Management Review Committee minutes for September 2007 through February 2008 9. DPS Record Management System printout for abuse/neglect incidents for December 2007 through February 2008 10. AD #810: Unit Security 11. Violence Abatement Task Tracking Form and other material

I.1.a	Each State hospital shall review, revise, as appropriate, and implement incident management policies, procedures and practices that are consistent with generally accepted professional standards of care. Such policies, procedures and practices shall require:	**Compliance:** Partial.
I.1.a.i	that each State hospital not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals;	**Current findings on previous recommendation:** **Recommendation, October 2007:** Continue current practice. **Findings:** In several investigations reviewed, investigators identified instances when staff members failed to report allegations on SIR forms and/or SOC 341 forms in a timely manner. In the 12/11/07 incident involving JR's allegation of verbal abuse, a staff member was determined to have failed to report. The finding was forwarded to Human Resources (HR). Similarly, a staff member who did not report an 11/17/07 allegation of verbal abuse until 12/20/07 was also referred to HR. As cited in I.1.c, HR took no action in these instances. **Current recommendations**: 1. Continue current practice of being alert to failure to report incidents in a timely manner and make the appropriate referrals. 2. Determine the appropriate response for the failure to report an allegation of staff misconduct and ensure action is taken in each instance.
I.1.a.ii	identification of the categories and definitions of incidents to be reported, and investigated; immediate reporting by staff to supervisory personnel and each State hospital's executive	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** DMH Headquarters: Write and distribute the Special Order governing

	director (or that official's designee) of serious incidents, including but not limited to, death, abuse, neglect, and serious injury, using standardized reporting across all settings, including school settings;	Headquarters Reportable incidents as expeditiously as possible. **Findings:** SO 227.08 Special Incident Reports was revised and became effective March 17, 2008. It defines Headquarters Reportable Special Incidents to include, but not be limited to, all suicide attempts, all injuries of unknown origin requiring medical treatment, all deaths, and allegations of abuse/neglect. Facilities have 60 days to complete all sections of the HQ Reportable Brief. **Recommendation 2, October 2007:** ASH: Begin completing the Analysis and Corrective Actions sections of the briefing forms. The Incident Review Committee has been designated as an appropriate forum for these discussions. **Findings:** The minutes of the Incident Management Review Committee and the review of seven HQ Reportable Briefs for the incidents involving LJ (2/23/08), SL (1/28/08), CC (2/23/08), KS (12/30/07), JW and ED (1/20/08), RD and EG (1/14/08) and JB (1/23/08) indicate that this recommendation has been partially implemented. The briefs all contain descriptions of the actions taken in response to the incident. These confirm that in the relevant cases, individuals were separated from aggressive peers and received timely medical care when injured. All address the number and adequacy of staffing at the time of the incident. The analysis section of the brief, which documents contributing factors, was not completed in five of the seven briefs. **Current recommendation:** Continue the current practice of having the Incident Management Review Committee review the HQ Reportable Briefs with particular attention to the identification of contributing factors.

I.1.a.iii	mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, and/or serious injury occur, staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators from direct contact with the involved individuals pending the outcome of the facility's investigation;	**Current findings on previous recommendation:** **Recommendation, October 2007:** Review the timing and implementation of the procedure for determining whether to remove a staff member as part of the review of incidents by the Incident Management Review Committee. **Findings:** In the investigations reviewed, documentation of the decision to remove or not remove a staff member involved in an incident was present and the decision was implemented in a timely manner--shortly after the incident was reported. For example, the named staff member in the verbal abuse allegation made on behalf of AS on 12/3/07 was removed from the unit on the same day. **Other findings:** The facility reports that the Incident Management Review Committee has been reviewing the decisions to remove or not remove a staff member but has not documented this review. The minutes will record this review beginning in April 2008. **Current recommendation**: Implement plans to record the IMRC's review of the decisions to remove staff members during an investigation in the minutes of the meetings.
I.1.a.iv	adequate competency-based training for all staff on recognizing and reporting potential signs and symptoms of abuse or neglect, including the precursors that may lead to abuse;	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Add the revised definitions to Incident Management Training and distribute the revised PowerPoint presentation as quickly as possible.

		Findings: A paper copy of the PowerPoint presentation used in Incident Management Training includes the revised SIR definitions. **Recommendation 2, October 2007:** Instruct Abuse and Neglect orientation and annual refresher trainers to teach/review the definitions with all classes. **Findings:** Sections from the same PowerPoint presentation cited above that include the revised definitions are used in orientation and annual refresher training. **Recommendation 3, October 2007:** Ensure that all hospital police receive annual A/N training and are familiar with the revised SIR definitions. **Findings:** The hospital police lieutenant said that as of April 2008, all hospital police had received Incident Management Training during which the revised definitions were presented and discussed. **Other findings:** In the investigations reviewed that were completed by the Office of Special Investigations, investigators cited and based conclusions related to abuse and neglect on the revised definitions. The chart in the cell below indicates that two of 11 staff members chosen for review were not current in taking annual abuse/neglect training. Two additional staff members were due for training during the month.

<table>
<tr><td></td><td></td><td>Current recommendation:
Continue efforts to ensure that staff members attend annual abuse/neglect training when they are due.</td></tr>
<tr><td>I.1.a.v</td><td>notification of all staff when commencing employment and adequate training thereafter of their obligation to report abuse or neglect to each State hospital and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept with their personnel records evidencing their recognition of their reporting obligations. Each State hospital shall not tolerate any mandatory reporter's failure to report abuse or neglect;</td><td>Current findings on previous recommendation:

Recommendation, October 2007:
Continue current practice.

Findings:
The personnel records of a sample of 11 staff members indicated that each had a cleared background check prior to hiring and with the exception of the staff member hired in 1985 before mandatory reporting was required, all had signed the Dependent Adult Mandatory Reporting acknowledgement form prior to hiring.

<table>
<tr><th>Staff Initials*</th><th>DA Mandated Reporter form signed</th><th>Criminal background cleared</th><th>Most recent abuse/neglect training</th></tr>
<tr><td>_C</td><td>9/24/01</td><td>9/13/01</td><td>3/18/08</td></tr>
<tr><td>_Q</td><td>11/01/05</td><td>9/02/05</td><td>4/10/07</td></tr>
<tr><td>_C</td><td>6/05/00</td><td>2/29/00</td><td>4/10/07</td></tr>
<tr><td>_G</td><td>4/04/94</td><td>4/04/94</td><td>1/17/07</td></tr>
<tr><td>_F</td><td>6/02/03</td><td>1/23/03</td><td>2/08/08</td></tr>
<tr><td>_R</td><td>12/29/85</td><td>6/20/85</td><td>8/18/07</td></tr>
<tr><td>_W</td><td>7/01/02</td><td>3/29/02</td><td>9/15/06</td></tr>
<tr><td>_P</td><td>7/01/96</td><td>4/29/96</td><td>5/07/07</td></tr>
<tr><td>_B</td><td>1/03/05</td><td>12/04/00</td><td>1/10/08</td></tr>
<tr><td>_F</td><td>2/01/00</td><td>12/01/99</td><td>3/14/08</td></tr>
<tr><td>_C</td><td>10/29/86</td><td>3/02/81</td><td>8/10/07</td></tr>
</table>
*Partial initials are provided to protect confidentiality.</td></tr>
</table>

		Other findings: See also I.1.a.i for incidents of failure to report in a timely manner that were discovered during the review of other incidents. See also I.1.c for instances in which the facility failed to take action in response to a staff member's failure to report an incident in a timely manner. **Current recommendation**: Determine the appropriate facility response when a staff member fails to report staff misconduct in a timely manner and ensure that action is taken and documented.
I.1.a.vi	mechanisms to inform individuals and their conservators how to identify and report suspected abuse or neglect;	**Current findings on previous recommendation:** **Recommendation, October 2007:** Move the task of getting approval of the letter to the Hospital Administrator, if the P&A office has not responded. **Findings:** The P&A office approved the letter to conservators and the letters were sent out. **Other findings:** A survey of the individuals is conducted each month. Responses to Question 14 for the months of December 2007 and January and February 2008 revealed that in aggregate, 82% of the respondents believed they could report abuse/neglect and rights violations, but slightly more than one-third of the respondents indicated abuse/neglect had not been explained to them.

<table>
<tr>
<td></td>
<td></td>
<td>
<table>
<tr><th>Question #14</th><th>Dec 2007
Yes answers</th><th>Jan 2008
Yes answers</th><th>Feb 2008
Yes answers</th></tr>
<tr><td>If you see A/N or a violation of your rights, can you report it?</td><td>76/98
77.6%</td><td>52/62
83.9%</td><td>58/68
85.3%</td></tr>
<tr><td>Has someone explained to you what is meant by abuse or neglect?</td><td>67/100
67%</td><td>41/65
63.1%</td><td>45/70
64.3%</td></tr>
</table>

A review of the rights acknowledgement forms for 16 randomly selected individuals on the units toured revealed that 12 had signed the acknowledgment within the last 12 months. Unit staff could not find the forms for two individuals, and two individuals, TS and FT, signed the form most recently on 1/20/05 and 11/18/04 respectively.

Current recommendations:
1. Determine the most appropriate forum for sponsoring a discussion with individuals of the revised definitions of abuse/neglect and other rights guaranteed them.
2. Include in the discussion the expectation that the rights will be reviewed with them at their annual review and they will be requested to sign the acknowledgement form.
</td>
</tr>
<tr>
<td>I.1.a.vii</td>
<td>posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to pursue such rights and how to report violations of such rights;</td>
<td>Current findings on previous recommendation:

Recommendation, October 2007:
Place the name of the current Patient Rights Advocate (PRA) on the posters.

Findings:
During the review of environmental conditions on several units, the Rights poster did not contain the name of the current Patient Rights</td>
</tr>
</table>

		Advocate. This was corrected while the court monitoring team was on site. Sticky labels were affixed to the posters with the correct name of the PRA. **Other findings:** Each unit reviewed had a copy of the Rights poster on the wall. Each unit also had a supply of blank forms for bringing a concern to the attention of the PRA. During the Hospital Advisory Council meeting, individuals indicated there were aspects of the PRA complaint process that were not clear to them and that they would like to discuss with the PRA. **Current recommendation**: Determine the best forum for an invitation to the PRA to discuss the complaint process with members of the HAC who have questions/concerns.
I.1.a.viii	procedures for referring, as appropriate, allegations of abuse or neglect to law enforcement; and	**Current findings on previous recommendation:** **Recommendation 1, October 2007:** Clarify the expectation that every investigation file, whether completed by the Department of Police Services (DPS) (criminal cases in most instances) or by the Office of Special Investigations (administrative investigations) contain a completed SIR. **Findings:** All of the investigation files reviewed contained a completed SIR; however, in five incidents either the SIR or SOC 341 (Dependent Adult Abuse Reporting Form) was not completed in a timely manner. Examples include the following.

Allegation Type	Date of Incident	Date of SIR	Date of SOC 341
Verbal abuse	2/29/08	3/18/08	
Verbal abuse	11/26/07		12/20/07
Verbal abuse	12/14/07 reported	1/9/08	12/20/08
Verbal abuse	11/17/07	1/18/08	12/20/08
Verbal abuse	12/21/07 reported	12/28/07	12/31/07

Recommendation 2, October 2007:
Institute on at least a sample basis an independent review of the investigations and monitoring forms completed by DPS and the Office of Special Investigations.

Findings:
This recommendation was implemented recently. Investigations of abuse and neglect and the monitoring forms are reviewed by the Hospital Administrator on a sample basis.

Other findings:
All investigations are completed by hospital police who have all completed Incident Management Training. Those cases that may warrant criminal prosecution are forwarded to the District Attorney for consideration.

The facility reports that Investigation Compliance Monitoring Forms were completed for all investigations done by the Office of Special Investigations. A memo dated November 19, 2007 was sent to DMH Headquarters describing procedures for the completion and review of the Investigation Compliance Monitoring Forms.

		Current recommendations: 1. Review SIRs for timeliness, completeness and accuracy and provide training/guidance to staff who repeatedly make errors. 2. Ensure the completion of Investigation Compliance Monitoring Forms and the aggregation of data from a sizeable sample of the forms, particularly for Special Investigator investigations where the numbers are small.
I.1.a.ix	mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Examine critically for possible fear of retaliation those instances when individuals decide they no longer want an investigation into an allegation they have made or when they change their telling of the circumstances of the incident to free the staff person of any wrongdoing. **Findings:** A directive was forwarded to patrol officers, police criminal investigators and Special Investigators by police supervisors in January 2008 requiring investigators to question any individual who withdraws or attempts to withdraw a complaint against a staff member in order to to determine if the withdrawal is due to threats or retaliation. Implementation of this directive and the recommendation cited above was evident in the investigation of the allegation of physical and verbal abuse made by PG (date of incident: 1/8/08) in which he said he did not wish to prosecute. The investigator conducted a second interview and asked PG if he had been threatened or coerced into not pursuing prosecution. PG stated this was not the case and assured the investigator that if he were threatened or coerced, he would report these actions to the officer. **Current recommendation**: Continue current practice of questioning individuals who change their

		mind about making an allegation or pursuing criminal charges.
I.1.b	Each State hospital shall review, revise, as appropriate, and implement policies and procedures to ensure the timely and thorough performance of investigations, consistent with generally accepted professional standards of care. Such policies and procedures shall:	**Compliance:** Partial.
I.1.b.i	require investigations of all deaths, as well as allegations of abuse, neglect, serious injury, and theft. The investigations shall be conducted by qualified investigator(s) who have no reporting obligations to the program or elements of the facility associated with the allegation and have expertise in conducting investigations and working with persons with mental disorders;	**Current findings on previous recommendation:** **Recommendation, October 2007:** The Court Monitor will be working with the facilities to develop a format for Mortality Review Committee deliberations and documentation. Implementation of his recommendations should occur as quickly as possible. **Findings:** ASH's death review processes do not comply with Special Order 205.05 and do not meet practice standards. Specifically, reviews of deaths by the M&M Committee (physicians peer review) have not been timely with several meetings canceled because of lack of a quorum. Those that were convened have occasionally identified areas for improvement, but there is no documentation of whether these efforts resulted in the desired changes. Additionally, some information provided to the Mortality Interdisciplinary Review Committee (MIRC) on behalf of the M&M Committee is not accurate. Finally, some nursing death reviews fail to address pertinent issues. These deficiencies rob the MIRC of information it needs to competently fulfill its obligations. • The M&M Committee did not meet in the four-month period November 2007 through February 2008. When it met in mid-March, six cases were pending--the oldest dating back to the previous July.

		• Review of the agendas for the M&M Committee (including for those meetings that were not held because of the lack of a quorum) indicates that the death of RH (#42 in the M & M's numbering system), dating back to May 2007, was not reviewed. It last appeared on the agenda for the November 8, 2007 meeting and was dropped from subsequent agendas. • Review of the M & M Committee minutes dated April 26, 2007 with an addendum dated 5/17/07 indicates that one of the suggestions forwarded to the Medical Executive Committee (related to the death of MM) reads: "Increase staffing to monitor patients more closely with irregular rounds." Since this same problem appeared a year later in the death of PR in which staff did not complete rounds in accordance with facility policy, it is unclear what, if any, action was taken following the death of MM. • The nursing review of the death of PR, completed on April 8, 2008, fails to pose and address the question raised by night shift rounds reportedly completed every 20 minutes that failed to find PR dead for several hours. The nursing review of the death of QW (date of death: October 26, 2007) also failed to identify areas of concern related to medication administration and documentation and the failure of unit staff to make rounds in a manner consistent with AD #810. • The minutes of the MIRC for March 20, 2008 state that the M & M Committee found "no deficiencies in any of the provisions of care" related to the death of JN (date of death: March 9, 2008). In fact, the M & M Committee had not yet reviewed the death of JN. Similarly, the minutes of the February 6, 2008 MIRC meeting regarding the death of JB (date of death: January 23, 2008) state, "The Medical Staff Mortality Review Committee Minutes were reviewed by the Chair of the MIRC." The M & M Committee had not yet met to review this death. It was reviewed on March 27, 2008, according to the minutes.

		Current recommendations: 1. In collaboration with DMH Headquarters and the other facilities, develop a mortality review system that meets the intent and requirements of SO 205.05. 2. Ensure the review of the death of RH (date of death: May 9, 2007) is completed. 3. Improve the quality of deficient nursing death reviews.
I.1.b.ii	ensure that only the State Hospital staff who have successfully completed competency-based training on the conduct of investigations be allowed to conduct investigations of allegations of petty theft and all other unusual incidents;	**Current findings on previous recommendation:** **Recommendation, October 2007:** Implement a process whereby at least on a sample basis investigations and the monitoring tools are reviewed by staff members not associated with the Dept. of Police Services. **Findings:** The facility reports that the Hospital Administrator reviewed six investigations and the monitoring tools completed for them in March 2008. This random review will continue. A memo dated November 19, 2007 from the Hospital Administrator to DMH states that the Incident Review Management Committee reviews completed investigations of abuse and neglect; following review by the Chief of Police Services, investigations and monitoring forms are reviewed by the Hospital Administrative Resident and disputed cases are brought before the Hospital Administrator. See also I.1.a.viii. **Current recommendation**: Revise the monitoring data to identify the number of investigations and monitoring forms reviewed by staff not associated with the DPS each month.

I.1.b.iii	investigations required by paragraph I.1.b.i, (above) provide for the safeguarding of evidence;	**Current findings on previous recommendation:** **Recommendation, October 2007:** Continue current practice. **Findings:** This monitor found no evidence in the investigation reports reviewed that investigators failed to safeguard physical evidence. Several investigations specifically documented the type of evidence obtained, the time it was obtained and how it was secured or transferred to another law enforcement authority. This was particularly the case in the investigations of deaths where the material collected could determine if foul play was involved and possibly by whom. **Current recommendation**: Continue current practice.
I.1.b.iv	investigations required by paragraph I.1.b.i, (above) require the development and implementation of standardized procedures and protocols for the conduct of investigations that are consistent with generally accepted professional standards. Such procedures and protocols shall require that:	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Require the interview of all persons relevant to an investigation and use the Investigation Compliance Monitoring Tool to ensure compliance with this expectation. **Findings:** All of the investigations reviewed included the interview of all relevant parties that were identified during the course of the investigation. **Recommendation 2, October 2007:** Continue to expand the work of the Incident Management Review Committee to identify corrective action recommendations.

		Findings: The Incident Management Review Committee has made recommendations for improving incident management at ASH, as reflected in the meeting minutes. The committee is maintaining a Task Tracking Form to track the recommendations, the staff person responsible, and date of the assignment. Review of this tracking form indicates that several assignments made to the Department of Police Services in late December 2007 had not been completed as of April 10, 2008. These relate to tracking A/N allegations received from external agencies and revising AD #825 to address this issue. **Current recommendation**: Require updates on at least a semi-monthly basis on tasks that appear to be taking too long to complete.
I.1.b.iv.1	investigations commence within 24 hours or sooner, if necessary, of the incident being reported	**Current findings on previous recommendations:** **Recommendation, October 2007:** Address the lack of timely initiation of OSI investigations by determining the source of the problem and taking corrective actions. **Findings:** There is improvement in the timely transfer of investigations from the hospital police to the Office of Special Investigator in the majority of investigations reviewed. One case was problematic, however. In the investigation of the allegation of physical abuse made by GL on 2/5/08, the hospital police conducted interviews on 2/8/08, but the case was not assigned to a Special Investigator until 2/27/08. [Some dates in this investigation are inaccurate; events are recorded as occurring in March that actually must have occurred in February.] **Other findings:** All incidents are initially investigated by the DPS officers. For those

		incidents that require investigation by the Special Investigator, the DPS investigation serves as a preliminary investigation that collects initial statements and identifies the individuals and staff involved. Thus, the quality of the work of the DPS officer completing the preliminary investigation directly impacts the OSI investigation. **Current recommendations**: 1. Complete the transfer of preliminary investigations from the hospital police to the Office of Special Investigation as expeditiously as possible to facilitate the timely assignment and initiation of interviews. 2. Ensure that the preliminary investigation clearly identifies attempts to identify all possible witnesses and documents the number of staff on the unit at the time of the incident.
I.1.b.iv. 2	investigations be completed within 30 business days of the incident being reported, except that investigations where material evidence is unavailable to the investigator, despite best efforts, may be completed within 5 business days of its availability;	**Current findings on previous recommendations:** **Recommendation, October 2007:** Calculate the number of cases not closed within 30 business days using the date open and the date closed, even when this spans more than one month. **Findings:** The facilities and Court Monitor have agreed on a consistent method for calculating compliance with this cell. **Other findings:** Six of the 17 investigations reviewed (35%) were not completed within 30 business days. This cannot be compared with facility data because it is too scarce. ASH data reported on only two cases in February completed by the Office of Special Investigations and no data for the earlier months in the review period. See I.1.a.viii.

		Current recommendation: Continue to work on the timely assignment of cases to Special Investigators, timely interviews, and closure with 30 business days.
I.1.b.iv. 3	each investigation result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action. The report's contents shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately:	**Current findings on previous recommendation:** **Recommendation, October 2007:** Identify in an appropriately labeled section of the investigation report any Areas of Concern identified during the investigation. **Findings:** The intent of this recommendation has been implemented. The closing section of the investigation report is used for this purpose. **Other findings:** The Investigation Compliance Monitoring Forms for most of the investigations reviewed was scored "NA" for the question related to recommendations for corrective actions. This is consistent with the contention that investigators are finders of fact and it is not their duty to make corrective action recommendations. While this distinction has been accepted, it remains the duty of the investigator to make a recommendation that any area of concern be further reviewed by the appropriate body. These referral recommendations should be specifically identified in the closing section of the investigation report. **Current recommendation**: Ensure that areas of concern are clearly identified in the investigation reports and the recommendation for referral to the appropriate body for further review and discussion is made.
I.1.b.iv. 3(i)	each allegation of wrongdoing investigated;	**Current findings on previous recommendation:**

		Recommendation, October 2007: Continue to identify instances where there is reason to believe that a staff member had reason to report an incident and failed to do so. **Findings:** See the findings reported in I.1.c. **Other findings:** The Level 1 Review of the allegation of verbal abuse made on behalf of JR does not match the allegation and reads as though the individual who reported the abuse was the offender threatening staff members. **Current recommendation**: Review SIRs and SOC 341s for completeness and accuracy.
I.1.b.iv. 3(ii)	the name(s) of all witnesses;	**Current findings on previous recommendations:** **Recommendation, October 2007:** Conduct interviews as quickly as possible and document attempts to identify witnesses (individuals and staff) not identified on the SIR. **Findings:** Delays in interviewing relevant parties were still problematic in several investigation reports reviewed: • In the investigation of the 12/15/07 allegation of verbal abuse made by RA (reported on 12/21/07), the named staff person was interviewed on 1/25/08. • In the investigation of the allegation of verbal abuse made by RB and reported to the Program on 1/22/08, the staff member named as a witness was interviewed on 3/6/08. • The Office of the Special Investigator received notice of an allegation of verbal abuse made by JR on 1/8/08. The first

		attempt to interview the individual occurred on 3/13/08. • In the review of the death of QW (October 22, 2007), the Unit Supervisor was interviewed on 12/19/07 and other relevant staff were interviewed on 1/5/08, 2/1/08 and 2/5/08. • In the investigation of the allegation of verbal abuse brought on behalf of KS on 12/20/07 regarding an incident that occurred a month earlier, KS was interviewed on 2/5/08 and did not remember the incident. **Other findings:** The hospital police claimed that some delays resulted from an insufficient number of Special Investigators at specific periods of time during the review period. The Office of the Special Investigator is now staffed sufficiently that delays should not occur because of staffing constraints. **Current recommendation:** Begin and conclude interviews as quickly as possible to gather recent memory information.
I.1.b.iv. 3(iii)	the name(s) of all alleged victims and perpetrators;	**Current findings on previous recommendation:** **Recommendation, October 2007:** Ensure that all DPS investigations are entered into the Record Management System as they are assigned and a copy of the data record is placed in the investigation folder as soon as the investigation is begun. **Findings:** This recommendation has been implemented. **Other findings:** Because it is not a secure database, the names of staff members

		alleged to have engaged in misconduct are not entered into the SIR database. In one incident report reviewed (1/8/08 allegation of physical abuse made by PG), the name of the staff member involved did not appear anywhere on the incident report. Staff names are maintained in the Record Management System maintained by the hospital police but, as detailed in I.1.d.i, the accuracy of some of this information is in question. **Current recommendation**: Determine how to provide investigators access to accurate information regarding the incident history of individuals and staff members as required by the EP.
I.1.b.iv. 3(iv)	the names of all persons interviewed during the investigation;	**Current findings on previous recommendation:** **Recommendation, October 2007:** Change the protocol for DPS investigations to require the interview of all relevant parties. **Findings:** This recommendation was implemented in the DPS investigations reviewed. **Other findings:** All investigations reviewed clearly identified the names of all persons interviewed. Several investigations documented attempts to find additional witnesses by asking the named parties if there were witnesses or if anyone else was in the area. The investigation of the allegation of physical abuse of JH on 12/28/07 is an example. The investigator also questioned staff about the quality of the named staff person's

		interactions with individuals in other situations. **Current recommendation:** Continue current OSI practice of documenting attempts to find additional witnesses among staff and individuals. Ensure DPS preliminary investigations also document these attempts as well as the number of staff present on the unit at the time of the incident.
I.1.b.iv. 3(v)	a summary of each interview;	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Question and document where all staff were when the incident occurred, and verify whether any individuals could have seen or heard the incident. **Findings:** This recommendation has been partially implemented. As stated above, investigators are documenting attempts to identify individuals and staff who may have witnessed an incident. Investigations need to state the number of staff on the unit at the time of the incident, so that the reader can conclude whether all relevant staff were interviewed. **Recommendation 2, October 2007:** Ask follow-up questions to attempt to reconcile conflicting information. **Findings:** In the investigation of the allegation of verbal abuse made on behalf of KS by a staff member against another staff member, KS was interviewed six weeks after the event and could not remember it. The reports of the two staff members were in conflict. The investigator concluded that the allegation was unfounded without attempting to reconcile the reports by, for example, asking other staff about the pattern of behavior of the named staff member with individuals. [Note

		that late reporting hampered the investigation.] **Current recommendations:** 1. State in investigation reports the number of staff who were present at the time of an incident, so that the reader can be assured that all relevant staff were interviewed. 2. Seek additional information when confronted with conflicting reports of an incident.
I.1.b.iv. 3(vi)	a list of all documents reviewed during the investigation;	**Current findings on previous recommendation:** **Recommendation, October 2007:** Continue expanding the work of the Incident Management Review Committee as described in AD #223. **Findings:** The work of the Incident Management Review Committee has expanded to include the review of HQ Reportable Briefs. The meeting minutes reflect the committee's recommendations for changes and/or additions. The committee also reviews the investigations of allegations of abuse and neglect. It considers timeliness, the rationale for the determination, "what went well" and concerns. As required by AD #223, the committee will begin reviewing quarterly incident trend and pattern reports in May 2008. **Other findings:** In the investigations reviewed, the investigation reports included a listing of all documents reviewed. The collection of relevant documents and/or quoting from relevant documents were noteworthy in several cases: • The relevant IDN was quoted in the investigation of the allegation

		of physical and verbal abuse made by PG on 1/8/08. • The staff attendance sheet for the day of the alleged physical abuse of GL (2/5/08) was included in the investigation report. • The sick call record, the physician's order sheet and the surgery record were reviewed and appended to the investigation of the neglect allegation made by KG on 2/7/08. **Current recommendations**: 1. Continue current practice of reviewing and referencing relevant documents 2. Begin the production of incident trend and pattern data for review by the Incident Management Review Committee as quickly as possible. This information should also be shared with other bodies working on the Violence Abatement Project.
I.1.b.iv. 3(vii)	all sources of evidence considered, including previous investigations and their results, involving the alleged victim(s) and perpetrator(s);	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Report monitoring data on a substantial sample of cases closed during any given month regardless of the month in which they were opened. **Findings:** The facilities and the Court Monitor have agreed on a method for calculating the timeliness of investigations. **Recommendation 2, October 2007:** Ensure that both DPS officers and supervisors understand the rigorous standards embodied in the Investigation Compliance Monitoring form and apply those standards appropriately. **Findings:** Improvement in the quality of the investigations indicates that this recommendation is being implemented.

		Recommendation 3, October 2007: Ensure that a sample of investigations and monitoring forms are reviewed by a party independent of DPS. **Findings:** See I.1.b.ii. **Recommendation 4, October 2007:** Ensure that the Incident Management Review Committee reviews the investigations of staff misconduct, including allegations of abuse/neglect, and the investigations of deaths and serious injuries, regardless of the determination (substantiated or unfounded). **Findings:** This recommendation has been implemented. The Incident Management Review Committee reviews all investigations of allegations of abuse/neglect, regardless of whether they are substantiated or not. **Other findings:** None of the investigation reports reviewed documented a review of the incident history of the named staff member or the individual. The facility is hampered in fulfilling this requirement because the SIR database does not contain the names of staff members involved in incidents and the DPS Record Management System needs to be cleaned to correct miscoding of type of involvement of staff and individuals. See I.1.d.i. **Current recommendation:** Develop a reliable method for permitting investigators to conduct and document in the investigation reports a review of the incident history of individuals and named staff members during investigations of allegations of staff misconduct.

I.1.b.iv. 3(viii)	the investigator's findings, including findings related to the substantiation of the allegations as well as findings about staff's adherence to programmatic requirements; and	**Current findings on previous recommendation:** **Recommendation, October 2007:** Continue to expand the work of the Incident Management Review Committee until it is undertaking all of its duties described in AD #223. **Findings:** See I.1.b.iv.3(vi). **Other findings:** All Office of Special Investigations investigation reports reviewed concluded with a determination of substantiated or not substantiated. Some addressed staff adherence to programmatic requirements, particularly the duty to report incidents. **Current recommendation**: Continue current practice of identifying, during investigations of allegations of abuse and neglect, violations of Administrative Directives and Special Orders related to staff conduct.
I.1.b.iv. 3(ix)	the investigator's reasons for his/her conclusions, including a summary indicating how potentially conflicting evidence was reconciled; and	**Current findings on previous recommendation:** **Recommendation, October 2007:** The Incident Management Review Committee should review the investigation of the allegation of misuse of seclusion described above and determine what, if any, corrective actions are appropriate. **Findings:** The Incident Management Review Committee determined that the use of seclusion was appropriate and made no recommendations for corrective actions.

		Other findings: The Record Management System can presently accommodate only a single determination, even in cases in which more than one issue is involved. Specifically, in the investigation of the allegation of verbal abuse made on behalf of KS on 12/20/07, the investigation found that the verbal abuse allegation was not substantiated. It also found that a staff member failed to report the incident in a timely manner. This pattern was repeated in the investigation of the allegation of verbal abuse made by JR on 12/11/07. In both instances, the Record Management Data Sheets show the allegation as verbal abuse only and a substantiated determination. In an interview, the police lieutenant acknowledged that when any wrongdoing on the part of staff is confirmed, the investigator enters a substantiated determination. This is problematic since the Record Management System is the primary tool for accessing determination data. It is presently reporting false positives for allegations of abuse/neglect. **Current recommendation**: Work with the vendor to determine how best to correct this problem. In the meantime, match the determination with the allegation shown on the RMS reports.
I.1.b.iv. 4	staff supervising investigations review the written report, together with any other relevant documentation, to ensure that the investigation is thorough and complete and that the report is accurate, complete, and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly. As necessary, staff responsible for investigations shall be provided with additional training and/or technical	**Current findings on previous recommendations:** **Recommendation, October 2007:** Consider using the Investigation Compliance Monitoring form as a supervisory tool, since it includes the elements of the EP that characterize an investigation that meets current practice standards. **Findings:** The improvement in the quality of investigations reviewed indicates success in conveying to hospital police and the Office of Special

	assistance to ensure the completion of investigations and investigation reports consistent with generally accepted professional standards of care.	Investigations the requirements of the EP for competent and complete investigations and may be attributable, at least in part, to the Incident Management Training. It further suggests that supervisors are more carefully reviewing completed investigations. **Other findings:** In the investigation of the allegation of medical neglect made by KG on 2/7/08, the investigator asked the Assistant Coordinator of Nursing Services to review the relevant records and provide an opinion regarding the quality and attentiveness of nursing care provided to KG. This reaching out for technical assistance is commendable and should be encouraged. **Current recommendation**: Continue current practice of investigators requesting clinical expert and other assistance when needed.
I.1.c	Each State Hospital shall ensure that whenever disciplinary or programmatic action is necessary to correct a situation or prevent reoccurrence, each State hospital shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Continue to expand the work of the Incident Management Review Committee so that it is fulfilling all of its functions. **Findings:** See I.1.b.iv.3(vi). **Other findings:** In response to the increased rate of peer-to-peer violence and following the March 30, 2008 homicide death of PR, the facility undertook measures to address peer-to-peer violence. Some measures were enacted immediately and others will require more time for implementation. The measures outlined in a memo from the Executive Director on 4/10/08 include:

- Surveyed all units to locate lightweight furniture that could be used as a weapon. Replaced this furniture with heavier pieces or secured the furniture so it could not be moved.
- Team charged to develop a proposal for a security unit to treat the most violent individuals.
- Locate and cost out new locks that will allow individuals to lock their rooms from the inside with an override available to staff.
- Locate and cost out motion-activated video surveillance that would record individual and staff movement during sleeping hours.
- Use red lens with flashlights to reduce sleep disruption.
- Recommend improvements to ensure organized proactive risk management and performance improvement.
- Ensure line-of-sight observation of hallways where individuals reside during sleeping hours.
- Revision of AD #810 Unit Security on April 23, 2008.

In the investigations reviewed, five staff members were found to have engaged in misconduct. Review of implementation of disciplinary or other personnel actions revealed the following:

Incident date	Misconduct confirmed	Action taken
12/3/07	Verbal abuse	Action pending
12/11/07	Failure to report	No action taken
11/17/07	Failure to report	No action taken
10/22/07	Violation of rounds policy	Pay reduction Staff member retired
10/22/07	Violation of rounds policy	Pay reduction Staff member retired

Compliance:
Partial.

		Current recommendations: 1. Ensure that appropriate remedial actions are taken when a staff member fails to report an incident in a timely manner. 2. Pursue the avenues identified for reducing peer-to-peer violence.
I.1.d	Each State hospital shall have a system to allow the tracking and trending of investigation results. Trends shall be tracked by at least the following categories:	**Compliance:** Partial.
I.1.d.i	type of incident;	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Distribute the trending data widely throughout the facility and to the Incident Management Review Committee. Accompany the numbers with a short narrative analysis. **Findings:** This recommendation has not yet been implemented. **Recommendation 2, October 2007:** Conform the "type" data to the revised SIR definitions. **Findings:** Review of the print-out from the DPS Record Management System for the period December 2007 through February 2008 reveals multiple errors in coding the involvement of individuals and staff and in the incident type. The facility acknowledges that there are inaccuracies in this database. Examples of these inaccuracies include: • In case #07122507 (allegation of physical abuse), the named staff person is identified as the subject and the individual as the victim. • In case #08010010 (allegation of physical abuse), the individual is listed as the subject and there is no one listed as the victim.

		• In case #08010123 (allegation of physical abuse), the staff member is listed as the subject, the individual is listed as the reporting party and no one is listed as the victim. • Case #08010175 is identified as a battery case, but the subject listed is a staff member and the victim is an individual. It should be coded an allegation of physical abuse. • Case #08020280 (alleged sexual abuse) shows two subjects, one an individual and one a staff member. If this is truly a case of sexual abuse, under the revised definitions the individual should be identified as the victim. These problems and the issue raised in I.1.b.iv.3(ix), describing the problem in using the DPS Record Management System data to determine an incident substantiation rate, make it presently unwise to use the DPS data for identifying individuals and staff repeatedly appearing as aggressors or as victims. Further, until corrections are made, the data are not useful to investigators in researching the incident history of staff and individuals involved in an incident under investigation. **Recommendation 3, October 2007:** Match type, location and time of incident data to help identify corrective measures. **Findings:** This recommendation has not yet been implemented. **Current recommendations**: 1. Clarify the business rules for the codes identifying the roles of staff and individuals in incidents entered into the Record Management System. Provide training as needed to avoid future problems. 2. Review past data entered by police officers into the Record

		Management System and correct errors. Closely review the data as close to the time it is entered as possible.
I.1.d.ii	staff involved and staff present;	**Current findings on previous recommendations:** **Recommendation, October 2007:** Develop a quarterly report on staff members who have been involved in incidents. Identify any patterns. **Findings:** The DPS presented to the Incident Management Review Committee in April 2008 a listing of incidents from January through March 2008 that included the type of incident and the names of repeat victims and aggressors (both staff and individuals). The Committee responded by requesting that subsequent reports show patterns related to "chronic victims and chronic perpetrators." As noted above and acknowledged by ASH, the inaccuracies in the database must be addressed before the data is useful for tracking and trending. **Current recommendation**: See recommendations in I.1.d.i.
I.1.d.iii	individuals directly and indirectly involved;	**Current findings on previous recommendations:** **Recommendation, October 2007:** Identify individuals who are repeat aggressors and those who are repeat victims as a first step. **Findings:** See I.1.d.ii. **Current recommendations**: 1. See I.1.d.i.

		2. Ensure SIR database and Record Management System are in agreement before running trending and pattern data from either.
I.1.d.iv	location of incident;	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Distribute the trending data widely throughout the facility and accompany the numbers with a short narrative analysis. **Findings:** This recommendation has not yet been implemented. **Recommendation 2, October 2007:** Match location with other incident data, e.g. type and time to enhance the facility's ability to identify and implement corrective measures. **Findings:** This recommendation has not yet been implemented. **Current recommendations**: 1. Clean the Record Management System, ensure it and the SIR database are in agreement and start running reports. 2. After review by the appropriate bodies, distribute the aggregate data reports widely and distribute the repeat victim and aggressor reports to the appropriate WRPTs with a request for review and response.
I.1.d.v	date and time of incident;	**Current findings on previous recommendation:** **Recommendation, October 2007:** Gather and analyze time and day data, matching it with other incident data to identify trends and contributing factors that can be mitigated.

		Findings: This recommendation has not yet been implemented. **Current recommendations**: See I.1.d.iv.
I.1.d.vi	cause(s) of incident; and	**Current findings on previous recommendation:** **Recommendation 1, October 2007:** Begin completing the concluding sections of the Headquarters Reportable Brief forms, as the identification of contributing factors is essential to the development of corrective measures. **Findings:** As reported in I.1.a.ii, the analysis section of the brief, which documents contributing factors, was not completed in five of the seven briefs reviewed. The WRPT updated the foci and interventions and made a referral to PBS in response to one individual's self-harm. The Analysis section of this HQ brief was completed. **Recommendation 2, October 2007:** DMH Central Office should continue work on the Special Order that will address Headquarters Reportable Briefs. **Findings:** SO 227.07 Special Incident Reports was finalized on March 17, 2008 and distributed to the facilities for immediate implementation. **Current recommendation**: Encourage staff members to complete the analysis section of the HQ briefs identifying contributing factors.

I.1.d.vii	outcome of investigation.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Ensure that the statewide Incident Management System includes the disposition of the investigation as a variable. **Findings:** The disposition of an investigation will be one of the variables in the statewide Incident Management System. **Other findings:** See I.1.b.iv.3(ix) for a description of the problems identified in the DPS Record Management System data related to the outcome of investigations. **Current recommendation**: Hand-tabulate determination data until the related problems in the DPS Record Management System are addressed by the vendor.
I.1.e	Each State hospital shall ensure that before permitting a staff person to work directly with any individual, each State hospital shall investigate the criminal history and other relevant background factors of that staff person, whether full-time or part-time, temporary or permanent, or a person who volunteers on a regular basis. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the facility. The facility shall ensure that a staff person or volunteer may not interact with individuals at each State hospital in instances where the investigation indicates that the staff	**Current findings on previous recommendation:** **Recommendation, October 2007:** Continue current practice. **Findings:** See the table in cell I.1.a.v that reports the dates of completion of background checks for a sample of staff members. See also cell I.1.a.iii regarding the inclusion in all investigations reviewed of documentation of the decision whether or not to reassign a staff person involved in an incident.

	person or volunteer may pose a risk of harm to such individuals.	**Compliance:** Substantial. **Current recommendation**: Continue the practice of documenting decisions regarding removing staff members involved in incidents from direct contact with individuals and initiate review of these decisions in the Incident Management Review Committee.

2. Performance Improvement		
I.2	Each State hospital shall develop, revise as appropriate, and implement performance improvement mechanisms that enable it to comply fully with this Plan, to detect timely and adequately problems with the provision of protections, treatment, rehabilitation, services and supports, and to ensure that appropriate corrective steps are implemented. Each State hospital shall establish a risk management process to improve the identification of individuals at risk and the provision of timely interventions and other corrective actions commensurate with the level of risk. The performance improvement mechanisms shall be consistent with generally accepted professional standards of care and shall include:	**Methodology:** Interviewed: 1. J. Dansereau, MD, Chief of Psychiatry 2. L. Person, Hospital Administrator 3. S. Joslin, Standards Compliance 4. D. Nelson, Director, Standards Compliance Reviewed: 1. Aggregate trigger data, Record Management System Data and SIR data 2. WRPT response data for selected triggers 3. AD #418 Key Indicator/Trigger Reporting 4. Seven clinical records for implementation of trigger responses Observed: Enhanced Trigger Review Committee Meeting
I.2.a	Mechanisms for the proper and timely identification of high-risk situations of an immediate nature as well as long-term systemic problems. These mechanisms shall include, but not be limited to:	**Compliance:** Partial.
I.2.a.i	data collection tools and centralized databases to capture and provide information on various categories of high-risk situations;	**Current findings on previous recommendation:** **Recommendation, October 2007:** Continue current practice. **Findings:** The facility continues to collect behavioral trigger data using the SIR database as the information source.

		Other findings: The facility reports that its review of the accuracy of the SIRs (as distinct from timeliness) yielded positive results. Overall, in the six months from September through February, 96% of the SIRs reviewed were accurately completed and the database entry was accurate for 94% of those incidents. The review of the timeliness of a sample of SIRs and SOC 341s as presented in I.1.a.viii suggests the need for the facility to include timeliness in its review of these forms. The facility reports problems in data for trigger 11.1, Non-Adherence to the WRP. This, the facility believes, is related to the MAPP attendance rosters not being entered into the database in a timely manner. In response, the facility recently began centralized data entry in the Recovery Mall. **Compliance:** Partial. **Current recommendation**: Add timeliness as a consideration in the review of SIRs and SOC341s.
I.2.a.ii	establishment of triggers and thresholds that address different levels of risk, as set forth in Appendix A; and	**Current findings on previous recommendation:** **Recommendation, October 2007:** Continue current plans to monitor the quality and the implementation of WRT responses to triggers. **Findings:** The plan to monitor the quality of WRPT responses to triggers has recently been implemented in the Enhanced Trigger Review Committee Meeting that convenes weekly and reviews in an interdisciplinary forum

		WRPTs' responses to selected first-level triggers. **Other findings:** As part of ASH's work on triggers and violence abatement, the facility is turning attention to risk factors specific to each individual. The risk factors cover five areas: self-injurious/suicidal behavior; emotional and physical risk factors for the use of seclusion and restraint; assault risk factors; medical risk factor; and fire-setting, elopement and victimization risk factors. The goal of this work is to identify and gather into a single accessible document the risk factors for each individual and revise them as needed. AD #418 Key Indicator/Trigger Reporting (effective January 15, 2008) establishes a system for identifying 17 high-risk situations that require a WRT Level 1 response. **Current recommendations:** 1. Continue the multidisciplinary review of triggers to identify appropriate responses and to track the individual's progress after implementation. 2. Continue the work of identifying the risk factors specific to each individual in a single, easily accessible document.
I.2.a.iii	identification of systemic trends and patterns of high risk situations.	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Consider changing the business rules and eliminating the sexual activity component of the abuse/neglect/exploitation trigger statewide and collect this information as a separate trigger. **Findings:** The facility reports that this recommendation was rejected after consultation with the other facilities. Further discussion resulted in a

		plan to reconsider this recommendation: Reasons for the reconsideration include: • The need to identify in the trigger data the number of allegations of abuse and neglect as defined in the revised definitions; • The inadvisability of using a different definition of abuse/neglect for trigger purposes than for SIR purposes and the likelihood that this will eventually lead to confusion; and, • The disjuncture between the counts of peer-to-peer non-consensual sexual activity at ASH and the other facilities. The count is different at ASH from that in the other facilities. At ASH, all intimate sexual contact is considered non-consensual, whereas this is not the case in the other facilities. **Recommendation 2, October 2007:** Meet with all staff providing data to Standards Compliance for the protection from harm triggers to ensure they have a clear understanding of the business rules governing their data. This will be necessary until the SIR database becomes the single reliable data source of the protection from harm triggers. **Findings:** Standards Compliance is reviewing all SIRs and reporting to the Program Directors common errors. The DPS and Standards Compliance are meeting monthly to conform their data on reportable incidents, ensuring there is a police report, SIR and for abuse/neglect allegations, a SOC 341 for each. **Other findings:** During the Enhanced Trigger Review Committee Meetings, the participants have access to the individuals' trigger histories, thus enabling them to identify persons who have engaged in trigger behaviors repeatedly and present as high risk to themselves or others.

		Current recommendation: Reconsider the recommendation to separate trigger data for abuse/neglect allegations from sexual contact data.
I.2.b	Mechanisms for timely interventions and other corrective actions by teams and disciplines to prevent or minimize risk of harm to individuals. These mechanisms shall include, but not be limited to:	**Compliance:** Partial.
I.2.b.i	a hierarchy of interventions by clinical teams that correspond to triggers and thresholds;	**Current findings on previous recommendation:** **Recommendation, October 2007:** Continue plans to expand the role of Standards Compliance in monitoring the quality and implementation of WRPTs' responses to triggers. **Findings:** See Findings in I.2.a.ii. **Other findings:** Standards Compliance has been monitoring the response of WRPTs to triggers. Data for January 2008 for selected triggers indicates that a response was received back from the WRPT to Standards Compliance for 10 of 36 triggers (28%). The facility reports that in the six-month period September 2007 through February 2008, fewer than half (42%) of the WRPTs reviewed responded to the report of a Level 1 trigger in a timely manner. In February, the most recent month of data, the response rate was 49%. Documentation and implementation of the responses reported back to Standards Compliance averaged 85% and 77% respectively during the six-month period. These figures reflect the status prior to the

		initiation of the Enhanced Trigger Review Committee Meetings. The clinical leadership at the facility also reported that the WRPT soon will be required to attach to its response a copy of the page from the WRP that documents the response. **Current recommendation**: Continue to raise the visibility of the need for timely, documented and effective responses to triggers.
I.2.b.ii	timely corrective actions by teams and/or disciplines to address systemic trends and patterns;	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Review the business rules for data counts with all providers of data. **Findings:** The facility reported that new SIR codes were distributed to all Program and Account Managers. **Recommendation 2, October 2007:** Begin looking for data patterns and trends as soon as the facility is confident the data is accurate and reliable. **Findings:** The facility has recognized the increase in aggression between peers and individual to staff and has taken measures to address the problem. See I.1.c and I.2.c for specific information on the extent of the problem and the facility's initial responses. **Current recommendation**: Continue analysis and discussion of methods for addressing aggression by individuals. Discuss the issue with the Hospital Advisory Council as well.

I.2.b.iii	formalized systems for the notification of teams and needed disciplines to support appropriate interventions and other corrective actions;	**Current findings on previous recommendation:** **Recommendation, October 2007:** Train programs in the use of the drop-down action list in the database to identify the corrective action taken in response to a trigger. **Findings:** According to staff members interviewed, the drop-down menu will be expanded shortly to include more options for actions taken in response to Level 1 triggers. The form for documenting the WRPT's interventions was revised and in use in April 2008. **Other findings:** Because the SIR is the data source for the behavioral triggers, notification of triggers depends on staff members recognizing when an SIR should be completed and completing it accurately and in a timely manner. Prior to the March 30 death of PR, his assailant threatened to hurt, perhaps kill him (depending on the intent of his street language), and others on the unit several times. He clearly threatened to kill staff members. No SIR was completed and consequently no trigger was initiated for the homicidal threat. **Current recommendation**: Include a review for staff of the types of incidents that require an SIR as part of the efforts to reduce violence at the facility.
I.2.b.iv	formalized systems for feedback from teams and disciplines to the standards compliance department regarding completed actions; and	**Current findings on previous recommendation:** **Recommendation, October 2007:** See I.2.b.iii. **Findings:** While there is a system for teams and disciplines to report back to

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<td>Standards Compliance the actions they have taken or plan to take, the response rate, as reported in I.2.b.i, needs to substantially improve.

Other findings:
Review of the clinical records of eight individuals who had reached Level 1 triggers yielded variable results as follows. The Level 1 triggers identified with an * are to be addressed within three business days; others are to be addressed at the next WRPC:

<table>
<tr><th>Trigger/Key indicator</th><th>Date activated</th><th>Response documented as completed in clinical record</th></tr>
<tr><td>4 or more interclass polypharmacy</td><td>4/16/08</td><td>4/22/08</td></tr>
<tr><td>Body weight</td><td>3/5/08</td><td>3/18/08</td></tr>
<tr><td>PRN usage *</td><td>4/2/08</td><td>4/7 and 4/8/08</td></tr>
<tr><td>Restraint use *</td><td>6/8/07</td><td>No evidence of response</td></tr>
<tr><td>Non-adherence to WRP *</td><td>4/16/08</td><td>No evidence the response was implemented</td></tr>
<tr><td>Body weight</td><td>1/11/08</td><td>2/6/08</td></tr>
</table>

The interventions proposed for the remaining two individuals reviewed stated that the WRP, BY CHOICE point allocation and IDNs were reviewed and the physician would consider a change in the WRP.

Current recommendation:
Continue to encourage documentation in the individual's clinical record of the WRPs response to the trigger and monitor for the same.</td>
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<tr>
<td>I.2.b.v</td>
<td>monitoring and oversight systems to support timely implementation of interventions and corrective actions and appropriate follow up.</td>
<td>Current findings on previous recommendations:

Recommendation, October 2007:
Continue with plans to expand the trigger reporting and monitoring.</td>
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		Findings: With the exception of medication variance data, which is collected only on Program IV and will be expanded to Program V shortly, all other triggers and key indicators are reported facility-wide. Additional monitoring efforts, particularly related to the effectiveness of interventions enacted in response to triggers, are occurring in the Enhanced Trigger Monitoring Committee and in requiring the WRPT to send a copy of the page of the WRP that addresses the trigger back to Program Management and to Standards Compliance. **Current recommendations**: 1. Continue the use of a multidisciplinary review process directed at both the WRPT's response to a trigger and the individual's response to the intervention. 2. Implement plans to increase monitoring to ensure that WRPTs are responding in a timely manner to triggers through such measures as requiring a copy of the portion of the WRP addressing the trigger in the WRPT's reply.
I.2.c	Utilize, on an ongoing basis, appropriate performance improvement mechanisms to assess and address the facility's compliance with its identified service goals.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Move forward with the strategic planning and its implementation. **Findings:** The trigger data indicates that individual- instigated aggressive acts have increased substantially since December 2007. This includes several categories of aggression: aggression toward a peer resulting in a serious injury, aggression toward a staff member resulting in serious injury, two or more aggressive acts to others in seven consecutive days, and four or more aggressive acts to others in 30 consecutive days as represented below:

	Average monthly incidence, Jul—Nov 2007	Average monthly incidence, Dec 2007—Mar 2008
Aggression to peer→major injury	5	15.5
Aggression to staff→major injury	4.6	10.5
2 or more agg. acts in 7 consecutive days	23.8	33.2
4 or more agg. acts in 30 consecutive days	4.4	11.5

These figures suggest that the facility is not meeting its goal of providing a safe environment for staff and individuals. The facility believes this increase is due, in part, to a change in the population, with more individuals coming from prison. In recognition of the increase, the facility has initiated a Violence Abatement Project.

Compliance:
Partial.

Current recommendations:
1. Implement and monitor the effectiveness of the Violence Abatement measures.
2. Correct the problems in the DPS Record Management System so that individuals who are repeatedly aggressive or victimized can be accurately identified and treated.

3. Environmental Conditions		
I.3	Each State hospital shall develop and implement a system to review regularly all units and areas of the hospital to which individuals being served have access to identify any potential environmental safety hazards and to develop and implement a plan to remedy any identified issues, consistent with generally accepted professional standards of care. Such a system shall require that:	**Methodology:** Interviewed: 1. S. Everett, Health and Safety Department (by phone) 2. L. Persons, Hospital Administrator 3. Several staff members during the tour 4. Several individuals during the tour Reviewed: 1. Suicide Prevention Compliancy Forms for September 2007 through February 2008 2. Security and Sanitation checklists on four units 3. Clinical records of eight individuals with the problem of incontinence. 4. Dayroom temperature reports for September 2007. 5. Training data for non-clinical Mall providers Toured: Five units—47, 22, 9, 27 and 29
I.3.a	Potential suicide hazards are identified and prioritized for systematic corrective action, and such action is implemented on a priority basis as promptly as feasible;	**Current findings on previous recommendations:** **Recommendation 1, October 2007:** Include the review of suicide attempts in the duties of the Process Management Team listed in AD #222. **Findings:** The facility reported that the Self-Harm/Prevention Committee reviews suicides and suicide attempts. This Committee is following self-harm incidents to determine the methods used and the action response. The 38 aggressive acts to self in January 2008 and the 50 aggressive acts to self in February included:

Act	# in January	# in February
Head banging	7	8
Hit/punch object	4	8
Hit, bite, burn, scratch self	14	15
Noose/item for hanging	0	2

Restraints were used in response to four of these incidents in January. Restraints were used as a response 12 times in February.

Recommendation 2, October 2007:
Review the toilet paper holder, partitions in bedrooms and bathrooms and the mesh guards in the stairwells to determine what can be done to lessen their potential for completing suicide.

Findings:
The facility undertook a review of the items cited which included, in part, a review of the pertinent incident data from 2001. The data indicated that no suicide attempts had been made using the stairwell screens, the toilet paper holders or the bedroom partitions. Bathroom partitions had been used. ASH determined that replacing or reconfiguring the mesh guards in the stairwells and installing sturdier partitions without upright stabilizers would require budget change proposals. All of the toilet paper holders were repositioned by April 2008. This was evident during the tour of the units.

Recommendation 3, October 2007:
Require reviewers to identify hanging hazards on the inspection forms to ensure that reviewers are all identifying the hazards.

Findings:
The Suicide Prevention Compliancy Forms evaluate 25 suicide hazards. The forms for September 2007 through February 2008 indicate compliance in the range of 97% to 100% for five of the six months. In

		October 2007 compliance was 93.7%. October was only month an inspector recognized that the bathroom partitions represented a suicide hazard, despite national studies showing bathrooms are often the site of suicides and attempts in congregate settings and the facility's own data showing suicide attempts using the bathroom partitions. **Other findings:** The common areas of the five units toured were clean, including the floors and walls. With the exception of one bathroom on Unit 27, all others were stocked with paper goods. The Security and Sanitation checklists reviewed on four of four units were complete for the prior day and had been completed for the day shift on the day of the tour. Lack of storage space for individuals' personal possessions is a problematic environmental issue. Until the storage units that will replace the lockers that were removed last year are placed in bedrooms, individuals are restricted to one cardboard box in their room. This resulted in individuals storing food, used beverage cups, toothbrushes, hair grooming supplies and clothing on the floor. **Compliance:** Partial. **Current recommendations**: 1. Explain and demonstrate to inspectors the multiple suicide hazards in bathrooms including, but not limited to, stall partitions. 2. Review the appropriateness of the restraint use as response to the incidents of self-harm. 3. Provide individuals with personal storage space as quickly as possible.

I.3.b	All areas of the hospital that are occupied by individuals being served have adequate temperature control and deviations shall be promptly corrected;	**Current findings on previous recommendations:** **Recommendation, October 2007:** Continue current practice of recording temperatures during the hottest months of the year. **Findings:** Unit dayroom temperature reports for September (the last warm month in the report period) indicate that temperatures ranged from the mid-60s to the mid-70s. **Other findings:** The units toured were comfortable. **Compliance:** Substantial—based on limited information. **Current recommendations**: Continue current practice.
I.3.c	Each State hospital reviews, revises, as appropriate, and implements procedures and practices so that individuals who are incontinent are assisted to change in a timely manner;	**Current findings on previous recommendation:** **Recommendation, October 2007:** Expand, as planned, the monitoring of persons with incontinence to all units and move the monitoring beyond the review of documentation. Include an observation of the individual and conversation if possible, asking if the individual feels his needs are being met. Include these activities on the monitoring form. **Findings:** The monitoring form includes observation of the individual.

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Other findings:
Review of the clinical records of eight of the 16 individuals identified as having the problem of incontinence yielded the following results.
<table>
<tr><th>Individual</th><th>Included in Focus 6</th><th>Interventions are appropriate and implemented</th></tr>
<tr><td>KG</td><td>Yes</td><td>Yes</td></tr>
<tr><td>DQ</td><td>Yes</td><td>Yes</td></tr>
<tr><td>JR</td><td>Yes</td><td>Yes</td></tr>
<tr><td>OP</td><td>Yes</td><td>No--no evidence of monthly meeting with RN</td></tr>
<tr><td>MW</td><td>Yes</td><td>Yes</td></tr>
<tr><td>RP</td><td>No</td><td>No interventions</td></tr>
<tr><td>AG</td><td>Yes</td><td>Yes</td></tr>
<tr><td>OR</td><td>Yes</td><td>Yes</td></tr>
</table>
These findings are not inconsistent with the facility's findings that in the three-month period December 2007 through February 2008, incontinence was identified in Focus 6 in 85% of the 20 cases monitored. ASH found that interventions were appropriate in only 18% of the cases reviewed—rising from 0% in December to 25% in February.

Compliance:
Partial.

Current recommendations:
Continue to monitor the care provided to individuals with incontinence problems and provide feedback to the WRPTs.
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<td>I.3.d</td>
<td>Each State hospital thoroughly reviews and revises, as appropriate, its policy and practice regarding sexual contact among individuals served at the</td>
<td>Current findings on previous recommendations:</td>
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	hospital. Each State hospital shall establish clear guidelines regarding staff response to reports of sexual contact and monitor staff response to incidents. Each State hospital documents comprehensively therapeutic interventions in the individual's charts in response to instances of sexual contact; and	**Recommendation 1, October 2007:** Seek legal advice about the status of consensual activity among individuals living at ASH and make any necessary changes in policies and procedures based on that advice. **Findings:** The facility responded that the MOU between ASH and the California Department of Corrections and Rehabilitation does not allow consensual sexual activity. The facility provided copies of the relevant sections of the Penal Code for reference. **Recommendation 2, October 2007:** Ensure physicians, psychiatrists and nurses are advised of the results of the facility's self-monitoring of the handling of sexual incidents so that they will focus on improving performance. **Findings:** The facility responded that beginning May 1, 2008 aggregate data on sexual incidents will be provided to WRP mentors and other relevant parties. "Drill-down" information will also be provided to the Clinical Administrator, program leadership and the Health and Safety Officer when follow-up for improvement in response is needed on an individual basis. The facility reported that at the present time, all incidents of sexual contact are monitored by Standards Compliance, and the Clinical Administrator is notified of incidents in which policies and procedures were not followed or in which follow-up with the individual did not occur. **Other findings:** Review of three incidents of sexual contact between individuals revealed that in one incident, the individual recanted the allegation

		that he had been strong-armed for sex. In the remaining two incidents, the individuals were counseled and the incidents were discussed with the individual by members of his team. In one incident, the problem reported by one individual that he was propositioned by another was handled by the team and no further incidents were reported. In the other incident, both individuals changed their stories repeatedly, claiming to have engaged in sexual activity and then claiming not to. Both were examined by a physician and counseled by the nurse (about STDs) and later by the WRPT. **Compliance:** Partial. **Current recommendation**: Provide data on the review of the sexual contact incident response monitoring using a standard monitoring form.
I.3.e	Each State hospital develops and implements clear guidelines stating the circumstances under which it is appropriate to utilize staff that is not trained to provide mental health services in addressing incidents involving individuals. Each State hospital ensures that persons who are likely to intervene in incidents are properly trained to work with individuals with mental health concerns.	**Current findings on previous recommendation:** **Recommendation, October 2007:** Continue current practice. **Findings:** The training data compiled in early March for 17 non-clinical staff who are presently providing Mall training indicates that 13 had yet to complete Group Facilitator training. The vast majority of the 13 had completed training in PMAB, Abuse/Neglect, BY CHOICE, and Mall Overview. The Executive Director sent a memo announcing a one-time Group Facilitator training and Instructional Strategies training to be offered on March 25, 2008. **Compliance:** Partial.

		Current recommendation: Ensure that non-clinical Mall training providers complete the required training package.

J. First Amendment and Due Process		
J		**Summary of Progress:** 1. The minutes of the Hospital Advisory Council (HAC) indicate that leadership staff regularly attend the meetings and answer questions. 2. HAC meetings are orderly and funnel concerns through a process of written proposals that are later reviewed. The committee determines the issues it will work on and in what priority order. 3. The HAC has recently formed two committees to address issues important to the quality of life of the individuals: a BY CHOICE committee with a representative from each unit that will meet monthly, and a Mall Curriculum Committee that will meet monthly with the Mall Director.
J	Each State hospital unconditionally permits individuals to exercise their constitutional rights of free speech, including the right to petition the government for redress of grievances without State monitoring, and provides them due process.	**Methodology:** <u>Interviewed</u>: 1. Several individuals on the units toured 2. Questioned speakers at the Hospital Advisory Council to clarify their concerns <u>Reviewed</u>: Hospital Advisory Council meeting minutes <u>Observed</u>: Hospital Advisory Council meeting
J		**Current findings on previous recommendation:** **Recommendation, October 2007:** Continue with plans to increase educational opportunities for individuals on their rights and responsibilities.

		Findings: Discussion at the Hospital Advisory Council (HAC) meeting made very clear that many of the individuals who spoke found the Mall groups intrusive, leaving them too little time for taking care of their personal needs, and often repetitive or irrelevant. This was due, in part, to a lack of understanding of the intended role of these groups in their recovery. When advised that reviewing the Enhancement Plan either individually or as a group might increase their understanding of these and other changes occurring at ASH, the individuals responded that the copies of the EP had been removed from the facility's library. Individuals also had questions about the procedures in the Patients' Right Advocates Office for handling their concerns. Individuals made a causal connection between the lack of storage space and the increase in peer aggression, suggesting that the stealing that results from insecure storage was one cause of the increase in aggression. **Compliance:** Partial. **Current recommendations**: 1. Seriously reconsider the decision to remove copies of the EP from the library. Conduct a Q&A session on the EP at a Hospital Advisory Council meeting, if the individuals are agreeable to this. 2. Communicate the concerns expressed by the HAC to the Patients' Right Advocate and facilitate a response. 3. Install bedroom door locks that will keep personal items safe as quickly as possible.